

113TH CONGRESS
1ST SESSION

H. R. 2300

To provide for incentives to encourage health insurance coverage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 6, 2013

Mr. PRICE of Georgia introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and the Workforce, Ways and Means, the Judiciary, Natural Resources, House Administration, Rules, Appropriations, the Budget, and Oversight and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for incentives to encourage health insurance coverage, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Empowering Patients First Act of 2013”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Repeal of PPACA and health care-related HCERA provisions.

Sec. 3. No mandate of guaranteed issue or community rating.

TITLE I—TAX INCENTIVES FOR MAINTAINING HEALTH INSURANCE COVERAGE

- Sec. 101. Refundable tax credit for health insurance costs of low-income individuals.
- Sec. 102. Advance payment of credit as premium payment for qualified health insurance.
- Sec. 103. Election of tax credit instead of alternative government or group plan benefits.
- Sec. 104. Deduction for qualified health insurance costs of individuals.
- Sec. 105. Limitation on abortion funding.
- Sec. 106. No government discrimination against certain health care entities.
- Sec. 107. Equal employer contribution rule to promote choice.
- Sec. 108. Limitations on State restrictions on employer auto-enrollment.
- Sec. 109. Credit for small employers adopting auto-enrollment and defined contribution options.
- Sec. 110. HSA modifications and clarifications.

TITLE II—HEALTH INSURANCE POOLING MECHANISMS FOR INDIVIDUALS

Subtitle A—Federal Grants for State Insurance Expenditures

- Sec. 201. Federal grants for State insurance expenditures.

Subtitle B—Health Care Access and Availability

- Sec. 211. Expansion of access and choice through individual and small employer membership associations (IMAs).

Subtitle C—Small Business Health Fairness

- Sec. 221. Short title.
- Sec. 222. Rules governing association health plans.
- Sec. 223. Clarification of treatment of single employer arrangements.
- Sec. 224. Enforcement provisions relating to association health plans.
- Sec. 225. Cooperation between Federal and State authorities.
- Sec. 226. Effective date and transitional and other rules.

TITLE III—INTERSTATE MARKET FOR HEALTH INSURANCE

- Sec. 301. Cooperative governing of individual health insurance coverage.

TITLE IV—SAFETY NET REFORMS

- Sec. 401. Requiring outreach and coverage before expansion of eligibility.
- Sec. 402. Easing administrative barriers to State cooperation with employer-sponsored insurance coverage.
- Sec. 403. Improving beneficiary choice in SCHIP.

TITLE V—LAWSUIT ABUSE REFORMS

- Sec. 501. Change in burden of proof based on compliance with best practice guidelines.
- Sec. 502. State grants to create administrative health care tribunals.
- Sec. 503. Authorization of payment of future damages to claimants in health care lawsuits.

- Sec. 504. Definitions.
 Sec. 505. Effect on other laws.
 Sec. 506. Applicability; effective date.

TITLE VI—WELLNESS AND PREVENTION

- Sec. 601. Providing financial incentives for treatment compliance.

TITLE VII—TRANSPARENCY AND INSURANCE REFORM MEASURES

- Sec. 701. Receipt and response to requests for claim information.

TITLE VIII—QUALITY

- Sec. 801. Prohibition on certain uses of data obtained from comparative effectiveness research or from patient-centered outcomes research; accounting for personalized medicine and differences in patient treatment response.
 Sec. 802. Establishment of performance-based quality measures.

TITLE IX—STATE TRANSPARENCY PLAN PORTAL

- Sec. 901. Providing information on health coverage options and health care providers.

TITLE X—PATIENT FREEDOM OF CHOICE

- Sec. 1001. Guaranteeing freedom of choice and contracting for patients under Medicare.
 Sec. 1002. Preemption of State laws limiting charges for eligible professional services.
 Sec. 1003. Health care provider licensure cannot be conditioned on participation in a health plan.
 Sec. 1004. Bad debt deduction for doctors to partially offset the cost of providing uncompensated care required to be provided under amendments made by the Emergency Medical Treatment and Labor Act.
 Sec. 1005. Right of contract with health care providers.

TITLE XI—INCENTIVES TO REDUCE PHYSICIAN SHORTAGES

Subtitle A—Federally Supported Student Loan Funds for Medical Students

- Sec. 1101. Federally supported student loan funds for medical students.

Subtitle B—Loan Forgiveness for Primary Care Providers

- Sec. 1111. Loan forgiveness for primary care providers.

TITLE XII—QUALITY HEALTH CARE COALITION

- Sec. 1201. Quality Health Care Coalition.

TITLE XIII—OFFSETS

Subtitle A—Discretionary Spending Limits

- Sec. 1301. Discretionary spending limits.

Subtitle B—Savings From Health Care Efficiencies

- Sec. 1311. Medicare DSH report and payment adjustments in response to coverage expansion.
- Sec. 1312. Reduction in Medicaid DSH.

Subtitle C—Fraud, Waste, and Abuse

- Sec. 1321. Provide adequate funding to HHS OIG and HCFAC.
- Sec. 1322. Improved enforcement of the Medicare secondary payor provisions.
- Sec. 1323. Strengthen Medicare provider enrollment standards and safeguards.
- Sec. 1324. Tracking banned providers across State lines.

1 **SEC. 2. REPEAL OF PPACA AND HEALTH CARE-RELATED**
 2 **HCERA PROVISIONS.**

3 (a) PPACA.—Effective as of the enactment of the
 4 Patient Protection and Affordable Care Act (Public Law
 5 111–148), such Act is repealed, and the provisions of law
 6 amended or repealed by such Act are restored or revived
 7 as if such Act had not been enacted.

8 (b) HEALTH CARE-RELATED PROVISIONS IN THE
 9 HEALTH CARE AND EDUCATION RECONCILIATION ACT OF
 10 2010.—Effective as of the enactment of the Health Care
 11 and Education Reconciliation Act of 2010 (Public Law
 12 111–152), title I and subtitle B of title II of such Act
 13 are repealed, and the provisions of law amended or re-
 14 pealed by such title or subtitle, respectively, are restored
 15 or revived as if such title and subtitle had not been en-
 16 acted.

17 **SEC. 3. NO MANDATE OF GUARANTEED ISSUE OR COMMU-**
 18 **NITY RATING.**

19 Nothing in this Act shall be construed to provide a
 20 mandate for guaranteed issue or community rating in the
 21 private insurance market.

1 **TITLE I—TAX INCENTIVES FOR**
2 **MAINTAINING HEALTH IN-**
3 **SURANCE COVERAGE**

4 **SEC. 101. REFUNDABLE TAX CREDIT FOR HEALTH INSUR-**
5 **ANCE COSTS OF LOW-INCOME INDIVIDUALS.**

6 (a) IN GENERAL.—Subpart C of part IV of sub-
7 chapter A of chapter 1 of the Internal Revenue Code of
8 1986, as amended by section 2, is amended by inserting
9 after section 36A the following new section:

10 **“SEC. 36B. HEALTH INSURANCE COSTS OF LOW-INCOME IN-**
11 **DIVIDUALS.**

12 “(a) IN GENERAL.—In the case of an individual,
13 there shall be allowed as a credit against the tax imposed
14 by subtitle A the aggregate amount paid by the taxpayer
15 for coverage of the taxpayer and the taxpayer’s qualifying
16 family members under qualified health insurance for eligi-
17 ble coverage months beginning in the taxable year.

18 “(b) LIMITATIONS.—

19 “(1) IN GENERAL.—The amount allowable as a
20 credit under subsection (a) for the taxable year shall
21 not exceed the lesser of—

22 “(A) the sum of the monthly limitations
23 for months during such taxable year that the
24 taxpayer or the taxpayer’s qualifying family
25 members is an eligible individual, and

1 “(B) the aggregate premiums paid by the
2 taxpayer for the taxable year for coverage de-
3 scribed in subsection (a).

4 “(2) MONTHLY LIMITATION.—The monthly lim-
5 itation for any month is the credit percentage of $\frac{1}{12}$
6 of the sum of—

7 “(A) \$2,000 for coverage of the taxpayer
8 (\$4,000 in the case of a joint return for cov-
9 erage of the taxpayer and the taxpayer’s
10 spouse), and

11 “(B) \$500 for coverage of each dependent
12 of the taxpayer.

13 “(3) CREDIT PERCENTAGE.—

14 “(A) IN GENERAL.—For purposes of this
15 section, the term ‘credit percentage’ means 100
16 percent reduced by 1 percentage point for each
17 \$1,000 (or fraction thereof) by which the tax-
18 payer’s adjusted gross income for the taxable
19 year exceeds the threshold amount.

20 “(B) THRESHOLD AMOUNT.—For purposes
21 of this paragraph, the term ‘threshold amount’
22 means, with respect to any taxpayer for any
23 taxable year, 200 percent of the Federal pov-
24 erty guideline (as determined by the Secretary

1 of Health and Human Services for the taxable
2 year) applicable to the taxpayer.

3 “(4) ONLY 2 DEPENDENTS TAKEN INTO AC-
4 COUNT.—Not more than 2 dependents of the tax-
5 payer may be taken into account under paragraphs
6 (2)(C) and (3)(B).

7 “(5) INFLATION ADJUSTMENT.—In the case of
8 any taxable year beginning in a calendar year after
9 2013, each dollar amount contained in paragraph
10 (2) shall be increased by an amount equal to—

11 “(A) such dollar amount, multiplied by

12 “(B) the cost-of-living adjustment deter-
13 mined under section 1(f)(3) for the calendar
14 year in which the taxable year begins, deter-
15 mined by substituting ‘calendar year 2012’ for
16 ‘calendar year 1992’ in subparagraph (B)
17 thereof.

18 Any increase determined under the preceding sen-
19 tence shall be rounded to the nearest multiple of
20 \$50.

21 “(c) ELIGIBLE COVERAGE MONTH.—For purposes of
22 this section, the term ‘eligible coverage month’ means,
23 with respect to any individual, any month if, as of the first
24 day of such month, the individual—

25 “(1) is covered by qualified health insurance,

1 “(2) does not have other specified coverage, and

2 “(3) is not imprisoned under Federal, State, or

3 local authority.

4 “(d) QUALIFYING FAMILY MEMBER.—For purposes

5 of this section, the term ‘qualifying family member’

6 means—

7 “(1) in the case of a joint return, the taxpayer’s

8 spouse, and

9 “(2) any dependent of the taxpayer.

10 “(e) QUALIFIED HEALTH INSURANCE.—For pur-

11 poses of this section, the term ‘qualified health insurance’

12 means health insurance coverage (other than excepted

13 benefits as defined in section 9832(c)) which constitutes

14 medical care.

15 “(f) OTHER SPECIFIED COVERAGE.—For purposes of

16 this section, an individual has other specified coverage for

17 any month if, as of the first day of such month—

18 “(1) COVERAGE UNDER MEDICARE, MEDICAID,

19 OR SCHIP.—Such individual—

20 “(A) is entitled to benefits under part A of

21 title XVIII of the Social Security Act or is en-

22 rolled under part B of such title, or

23 “(B) is enrolled in the program under title

24 XIX or XXI of such Act (other than under sec-

25 tion 1928 of such Act).

1 “(2) CERTAIN OTHER COVERAGE.—Such indi-
2 vidual—

3 “(A) is enrolled in a health benefits plan
4 under chapter 89 of title 5, United States Code,

5 “(B) is entitled to receive benefits under
6 chapter 55 of title 10, United States Code,

7 “(C) is entitled to receive benefits under
8 chapter 17 of title 38, United States Code,

9 “(D) is enrolled in a group health plan
10 (within the meaning of section 5000(b)(1))
11 which is subsidized by the employer, or

12 “(E) is a member of a health care sharing
13 ministry.

14 “(3) HEALTH CARE SHARING MINISTRY.—For
15 purposes of this subsection, the term ‘health care
16 sharing ministry’ means an organization—

17 “(A) which is described in section
18 501(c)(3) and is exempt from taxation under
19 section 501(a),

20 “(B) members of which share a common
21 set of ethical or religious beliefs and share med-
22 ical expenses among members in accordance
23 with those beliefs and without regard to the
24 State in which a member resides or is em-
25 ployed,

1 “(C) members of which retain membership
2 even after they develop a medical condition,

3 “(D) which (or a predecessor of which) has
4 been in existence at all times since December
5 31, 1999, and medical expenses of its members
6 have been shared continuously and without
7 interruption since at least December 31, 1999,
8 and

9 “(E) which conducts an annual audit
10 which is performed by an independent certified
11 public accounting firm in accordance with gen-
12 erally accepted accounting principles and which
13 is made available to the public upon request.

14 “(g) SPECIAL RULES.—

15 “(1) COORDINATION WITH ADVANCE PAYMENTS
16 OF CREDIT; RECAPTURE OF EXCESS ADVANCE PAY-
17 MENTS.—With respect to any taxable year—

18 “(A) the amount which would (but for this
19 subsection) be allowed as a credit to the tax-
20 payer under subsection (a) shall be reduced
21 (but not below zero) by the aggregate amount
22 paid on behalf of such taxpayer under section
23 7529 for months beginning in such taxable
24 year, and

1 “(B) the tax imposed by section 1 for such
2 taxable year shall be increased by the excess (if
3 any) of—

4 “(i) the aggregate amount paid on be-
5 half of such taxpayer under section 7529
6 for months beginning in such taxable year,
7 over

8 “(ii) the amount which would (but for
9 this subsection) be allowed as a credit to
10 the taxpayer under subsection (a).

11 “(2) COORDINATION WITH OTHER DEDUC-
12 TIONS.—Amounts taken into account under sub-
13 section (a) shall not be taken into account in deter-
14 mining—

15 “(A) any deduction allowed under section
16 162(l), 213, or 224, or

17 “(B) any credit allowed under section 35.

18 “(3) MEDICAL AND HEALTH SAVINGS AC-
19 COUNTS.—Amounts distributed from an Archer
20 MSA (as defined in section 220(d)) or from a health
21 savings account (as defined in section 223(d)) shall
22 not be taken into account under subsection (a).

23 “(4) DENIAL OF CREDIT TO DEPENDENTS AND
24 NONPERMANENT RESIDENT ALIEN INDIVIDUALS.—

1 No credit shall be allowed under this section to any
2 individual who is—

3 “(A) not a citizen or lawful permanent
4 resident of the United States for the calendar
5 year in which the taxable year begins, or

6 “(B) a dependent with respect to another
7 taxpayer for a taxable year beginning in the
8 calendar year in which such individual’s taxable
9 year begins.

10 “(5) INSURANCE WHICH COVERS OTHER INDI-
11 VIDUALS.—For purposes of this section, rules simi-
12 lar to the rules of section 213(d)(6) shall apply with
13 respect to any contract for qualified health insurance
14 under which amounts are payable for coverage of an
15 individual other than the taxpayer and qualifying
16 family members.

17 “(6) TREATMENT OF PAYMENTS.—For pur-
18 poses of this section—

19 “(A) PAYMENTS BY SECRETARY.—Pay-
20 ments made by the Secretary on behalf of any
21 individual under section 7529 (relating to ad-
22 vance payment of credit for health insurance
23 costs of low-income individuals) shall be treated
24 as having been made by the taxpayer on the

1 first day of the month for which such payment
2 was made.

3 “(B) PAYMENTS BY TAXPAYER.—Pay-
4 ments made by the taxpayer for eligible cov-
5 erage months shall be treated as having been
6 made by the taxpayer on the first day of the
7 month for which such payment was made.

8 “(7) REGULATIONS.—The Secretary may pre-
9 scribe such regulations and other guidance as may
10 be necessary or appropriate to carry out this section,
11 section 6050W, and section 7529.”.

12 (b) CONFORMING AMENDMENTS.—

13 (1) Paragraph (2) of section 1324(b) of title
14 31, United States Code, as amended by section 2, is
15 amended by inserting “36B,” after “36A,”.

16 (2) The table of sections for subpart C of part
17 IV of subchapter A of chapter 1 of the Internal Rev-
18 enue Code of 1986, as amended by section 2, is
19 amended by inserting after the item relating to sec-
20 tion 36A the following new item:

“Sec. 36B. Health insurance costs of low-income individuals.”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to taxable years beginning after
23 December 31, 2013.

24 (d) SENSE OF CONGRESS.—It is the sense of Con-
25 gress that the cost of the advanceable refundable credit

1 under sections 36B and 7529 of the Internal Revenue
2 Code of 1986, as added by this title, will be offset by sav-
3 ings derived from the provisions of title XIII.

4 **SEC. 102. ADVANCE PAYMENT OF CREDIT AS PREMIUM**
5 **PAYMENT FOR QUALIFIED HEALTH INSUR-**
6 **ANCE.**

7 (a) IN GENERAL.—Chapter 77 of the Internal Rev-
8 enue Code of 1986 (relating to miscellaneous provisions)
9 is amended by adding at the end the following:

10 **“SEC. 7529. ADVANCE PAYMENT OF CREDIT AS PREMIUM**
11 **PAYMENT FOR QUALIFIED HEALTH INSUR-**
12 **ANCE.**

13 “(a) GENERAL RULE.—Not later than January 1,
14 2014, the Secretary shall establish a program for making
15 payments to providers of qualified health insurance (as de-
16 fined in section 36B(e)) on behalf of taxpayers eligible for
17 the credit under section 36B. Except as otherwise pro-
18 vided by the Secretary, such payments shall be made on
19 the basis of the adjusted gross income of the taxpayer for
20 the preceding taxable year.

21 “(b) CERTIFICATION PROCESS AND PROOF OF COV-
22 ERAGE.—For purposes of this section, payments may be
23 made pursuant to subsection (a) only with respect to indi-
24 viduals for whom a qualified health insurance costs credit
25 eligibility certificate is in effect.”.

1 (b) DISCLOSURE OF RETURN INFORMATION FOR
2 PURPOSES OF ADVANCE PAYMENT OF CREDIT AS PRE-
3 MIUMS FOR QUALIFIED HEALTH INSURANCE.—

4 (1) IN GENERAL.—Subsection (l) of section
5 6103 of such Code, as amended by section 2, is
6 amended by adding at the end the following new
7 paragraph:

8 “(21) DISCLOSURE OF RETURN INFORMATION
9 FOR PURPOSES OF ADVANCE PAYMENT OF CREDIT
10 AS PREMIUMS FOR QUALIFIED HEALTH INSUR-
11 ANCE.—The Secretary may, on behalf of taxpayers
12 eligible for the credit under section 36B, disclose to
13 a provider of qualified health insurance (as defined
14 in section 36(e)), and persons acting on behalf of
15 such provider, return information with respect to
16 any such taxpayer only to the extent necessary (as
17 prescribed by regulations issued by the Secretary) to
18 carry out the program established by section 7529
19 (relating to advance payment of credit as premium
20 payment for qualified health insurance).”

21 (2) CONFIDENTIALITY OF INFORMATION.—
22 Paragraph (3) of section 6103(a) of such Code, as
23 amended by section 2, is amended by striking “or
24 (20)” and inserting “(20), or (21)”.

1 (3) UNAUTHORIZED DISCLOSURE.—Paragraph
2 (2) of section 7213(a) of such Code, as amended by
3 section 2, is amended by striking “or (20)” and in-
4 serting “(20), or (21)”.

5 (c) INFORMATION REPORTING.—

6 (1) IN GENERAL.—Subpart B of part III of
7 subchapter A of chapter 61 of such Code (relating
8 to information concerning transactions with other
9 persons) is amended by adding at the end the fol-
10 lowing new section:

11 **“SEC. 6050X. RETURNS RELATING TO CREDIT FOR HEALTH**
12 **INSURANCE COSTS OF LOW-INCOME INDIVID-**
13 **UALS.**

14 “(a) REQUIREMENT OF REPORTING.—Every person
15 who is entitled to receive payments for any month of any
16 calendar year under section 7529 (relating to advance pay-
17 ment of credit as premium payment for qualified health
18 insurance) with respect to any individual shall, at such
19 time as the Secretary may prescribe, make the return de-
20 scribed in subsection (b) with respect to each such indi-
21 vidual.

22 “(b) FORM AND MANNER OF RETURNS.—A return
23 is described in this subsection if such return—

24 “(1) is in such form as the Secretary may pre-
25 scribe, and

1 “(2) contains—

2 “(A) the name, address, and TIN of each
3 individual referred to in subsection (a),

4 “(B) the number of months for which
5 amounts were entitled to be received with re-
6 spect to such individual under section 7529 (re-
7 lating to advance payment of credit as premium
8 payment for qualified health insurance),

9 “(C) the amount entitled to be received for
10 each such month, and

11 “(D) such other information as the Sec-
12 retary may prescribe.

13 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
14 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
15 QUIRED.—Every person required to make a return under
16 subsection (a) shall furnish to each individual whose name
17 is required to be set forth in such return a written state-
18 ment showing—

19 “(1) the name and address of the person re-
20 quired to make such return and the phone number
21 of the information contact for such person, and

22 “(2) the information required to be shown on
23 the return with respect to such individual.

24 The written statement required under the preceding sen-
25 tence shall be furnished on or before January 31 of the

1 year following the calendar year for which the return
2 under subsection (a) is required to be made.”.

3 (2) ASSESSABLE PENALTIES.—

4 (A) Subparagraph (B) of section
5 6724(d)(1) of such Code, as amended by sec-
6 tion 2, is amended by striking “or” at the end
7 of clause (xxii), by striking “and” at the end of
8 clause (xxiii) and inserting “or”, and by insert-
9 ing after clause (xxiii) the following new clause:

10 “(xxiv) section 6050X (relating to re-
11 turns relating to credit for health insur-
12 ance costs of low-income individuals),
13 and”.

14 (B) Paragraph (2) of section 6724(d) of
15 such Code, as amended by section 2, is amend-
16 ed by striking “or” at the end of subparagraph
17 (EE), by striking the period at the end of sub-
18 paragraph (FF) and inserting “, or”, and by
19 adding after subparagraph (FF) the following
20 new subparagraph:

21 “(GG) section 6050X (relating to returns
22 relating to credit for health insurance costs of
23 low-income individuals).”.

24 (d) CLERICAL AMENDMENTS.—

1 (1) The table of sections for chapter 77 of such
2 Code is amended by adding at the end the following
3 new item:

 “Sec. 7529. Advance payment of credit as premium payment for qualified
 health insurance.”.

4 (2) The table of sections for subpart B of part
5 III of subchapter A of chapter 61 of such Code is
6 amended by adding at the end the following new
7 item:

 “Sec. 6050X. Returns relating to credit for health insurance costs of low-in-
 come individuals.”.

8 (e) EFFECTIVE DATE.—The amendments made by
9 this section shall take effect on the date of the enactment
10 of this Act.

11 **SEC. 103. ELECTION OF TAX CREDIT INSTEAD OF ALTER-**
12 **NATIVE GOVERNMENT OR GROUP PLAN BEN-**
13 **EFITS.**

14 (a) IN GENERAL.—Notwithstanding any other provi-
15 sion of law, an individual who is otherwise eligible for ben-
16 efits under a health program (as defined in subsection (e))
17 may elect, in a form and manner specified by the Sec-
18 retary of Health and Human Services in consultation with
19 the Secretary of the Treasury, to receive a tax credit de-
20 scribed in section 36B of the Internal Revenue Code of
21 1986 (which may be used for the purpose of health insur-
22 ance coverage) in lieu of receiving any benefits under such
23 program.

1 (b) EFFECTIVE DATE.—An election under subsection
2 (a) may first be made for calendar year 2014 and any
3 such election shall be effective for such period (not less
4 than one calendar year) as the Secretary of Health and
5 Human Services shall specify, in consultation with the
6 Secretary of the Treasury.

7 (c) HEALTH PROGRAM DEFINED.—For purposes of
8 this section, the term “health program” means any of the
9 following:

10 (1) MEDICARE.—The Medicare program under
11 part A of title XVIII of the Social Security Act.

12 (2) MEDICAID.—The Medicaid program under
13 title XIX of such Act (including such a program op-
14 erating under a Statewide waiver under section 1115
15 of such Act).

16 (3) SCHIP.—The State children’s health insur-
17 ance program under title XXI of such Act.

18 (4) TRICARE.—The TRICARE program
19 under chapter 55 of title 10, United States Code.

20 (5) VETERANS BENEFITS.—Coverage for bene-
21 fits under chapter 17 of title 38, United States
22 Code.

23 (6) FEHBP.—Coverage under chapter 89 of
24 title 5, United States Code.

1 (7) SUBSIDIZED GROUP HEALTH PLANS.—Cov-
 2 erage under a group health plan (within the meaning
 3 of section 5000(b)(1)) which is subsidized by the
 4 employer.

5 (d) OTHER SOCIAL SECURITY BENEFITS NOT
 6 WAIVED.—An election to waive the benefits described in
 7 subsection (c)(1) shall not result in the waiver of any other
 8 benefits under the Social Security Act.

9 **SEC. 104. DEDUCTION FOR QUALIFIED HEALTH INSURANCE**
 10 **COSTS OF INDIVIDUALS.**

11 (a) IN GENERAL.—Part VII of subchapter B of chap-
 12 ter 1 of the Internal Revenue Code of 1986 (relating to
 13 additional itemized deductions) is amended by redesignig-
 14 nating section 224 as section 225 and by inserting after
 15 section 223 the following new section:

16 **“SEC. 224. COSTS OF QUALIFIED HEALTH INSURANCE.**

17 “(a) IN GENERAL.—In the case of an individual,
 18 there shall be allowed as a deduction an amount equal to
 19 the amount paid during the taxable year for coverage for
 20 the taxpayer, his spouse, and dependents under qualified
 21 health insurance.

22 “(b) LIMITATION.—In the case of any taxpayer for
 23 any taxable year, the deduction under subsection (a) shall
 24 not exceed an amount that would cause the taxpayer’s
 25 Federal income tax liability to be reduced by more than

1 the average value of the national health exclusion for em-
2 ployer-sponsored insurance as determined by calculating
3 the value of the exclusion for each household followed by
4 calculating the average of those values.

5 “(c) QUALIFIED HEALTH INSURANCE.—For pur-
6 poses of this section, the term ‘qualified health insurance’
7 has the meaning given such term by section 36B(e).

8 “(d) SPECIAL RULES.—

9 “(1) COORDINATION WITH MEDICAL DEDUC-
10 TION, ETC.—Any amount paid by a taxpayer for in-
11 surance to which subsection (a) applies shall not be
12 taken into account in computing the amount allow-
13 able to the taxpayer as a deduction under section
14 162(l) or 213(a). Any amount taken into account in
15 determining the credit allowed under section 35 or
16 36B shall not be taken into account for purposes of
17 this section.

18 “(2) DEDUCTION NOT ALLOWED FOR SELF-EM-
19 PLOYMENT TAX PURPOSES.—The deduction allow-
20 able by reason of this section shall not be taken into
21 account in determining an individual’s net earnings
22 from self-employment (within the meaning of section
23 1402(a)) for purposes of chapter 2.”.

24 (b) DEDUCTION ALLOWED IN COMPUTING AD-
25 JUSTED GROSS INCOME.—Subsection (a) of section 62 of

1 such Code is amended by inserting before the last sentence
2 the following new paragraph:

3 “(22) COSTS OF QUALIFIED HEALTH INSUR-
4 ANCE.—The deduction allowed by section 224.”.

5 (c) CLERICAL AMENDMENT.—The table of sections
6 for part VII of subchapter B of chapter 1 of such Code
7 is amended by redesignating the item relating to section
8 224 as an item relating to section 225 and inserting before
9 such item the following new item:

 “Sec. 224. Costs of qualified health insurance.”.

10 (d) EFFECTIVE DATE.—The amendments made by
11 this section shall apply to taxable years beginning after
12 December 31, 2013.

13 **SEC. 105. LIMITATION ON ABORTION FUNDING.**

14 No funds authorized under, or credits or deductions
15 allowed under the Internal Revenue Code of 1986 by rea-
16 son of, this Act (or any amendment made by this Act)
17 may be used to pay for any abortion or to cover any part
18 of the costs of any health plan that includes coverage of
19 abortion, except in the case where a woman suffers from
20 a physical disorder, physical injury, or physical illness that
21 would, as certified by a physician, place the woman in dan-
22 ger of death unless an abortion is performed, including
23 a life-endangering physical condition caused by or arising
24 from the pregnancy itself, or unless the pregnancy is the
25 result of an act of rape or incest.

1 **SEC. 106. NO GOVERNMENT DISCRIMINATION AGAINST**
2 **CERTAIN HEALTH CARE ENTITIES.**

3 (a) NON-DISCRIMINATION.—A Federal agency or
4 program, and any State or local government that receives
5 Federal financial assistance under this Act or any amend-
6 ment made by this Act (either directly or indirectly), may
7 not subject any individual or institutional health care enti-
8 ty to discrimination on the basis that the health care enti-
9 ty does not provide, pay for, provide coverage of, or refer
10 for abortions.

11 (b) HEALTH CARE ENTITY DEFINED.—For purposes
12 of this section, the term “health care entity” includes an
13 individual physician or other health care professional, a
14 hospital, a provider-sponsored organization, a health
15 maintenance organization, a health insurance plan, or any
16 other kind of health care facility, organization, or plan.

17 (c) REMEDIES.—

18 (1) IN GENERAL.—The courts of the United
19 States shall have jurisdiction to prevent and redress
20 actual or threatened violations of this section by
21 issuing any form of legal or equitable relief, includ-
22 ing—

23 (A) injunctions prohibiting conduct that
24 violates this section; and

25 (B) orders preventing the disbursement of
26 all or a portion of Federal financial assistance

1 to a State or local government, or to a specific
2 offending agency or program of a State or local
3 government, until such time as the conduct pro-
4 hibited by this section has ceased.

5 (2) COMMENCEMENT OF ACTION.—An action
6 under this subsection may be instituted by—

7 (A) any health care entity that has stand-
8 ing to complain of an actual or threatened vio-
9 lation of this section; or

10 (B) the Attorney General of the United
11 States.

12 (d) ADMINISTRATION.—The Secretary of Health and
13 Human Services shall designate the Director of the Office
14 for Civil Rights of the Department of Health and Human
15 Services—

16 (1) to receive complaints alleging a violation of
17 this section;

18 (2) subject to paragraph (3), to pursue the in-
19 vestigation of such complaints in coordination with
20 the Attorney General; and

21 (3) in the case of a complaint related to a Fed-
22 eral agency (other than with respect to the Depart-
23 ment of Health and Human Services) or program
24 administered through such other agency or any
25 State or local government receiving Federal financial

1 assistance through such other agency, to refer the
2 complaint to the appropriate office of such other
3 agency.

4 **SEC. 107. EQUAL EMPLOYER CONTRIBUTION RULE TO PRO-**
5 **MOTE CHOICE.**

6 (a) IN GENERAL.—Section 5000 of the Internal Rev-
7 enue Code of 1986 is amended by adding at the end the
8 following new subsection:

9 “(e) HEALTH CARE CONTRIBUTION ELECTION.—

10 “(1) IN GENERAL.—Subsection (a) shall not
11 apply in the case of a group health plan with respect
12 to which the requirements of paragraphs (2) and (3)
13 are met.

14 “(2) CONTRIBUTION ELECTION.—The require-
15 ment of this paragraph is met with respect to a
16 group health plan if any employee of an employer
17 (who but for this paragraph would be covered by
18 such plan) may elect to have the employer or em-
19 ployee organization pay an amount which is not less
20 than the contribution amount to any provider of
21 health insurance coverage (other than excepted bene-
22 fits as defined in section 9832(c)) which constitutes
23 medical care of the individual or individual’s spouse
24 or dependents in lieu of such group health plan cov-

1 erage otherwise provided or contributed to by the
2 employer with respect to such employee.

3 “(3) PRE-EXISTING CONDITIONS.—

4 “(A) IN GENERAL.—The requirement of
5 this paragraph is met with respect to health in-
6 surance coverage provided to a participant or
7 beneficiary by any health insurance issuer if,
8 under such plan the requirements of section
9 9801 are met with respect to the participant or
10 beneficiary.

11 “(B) ENFORCEMENT WITH RESPECT TO
12 INDIVIDUAL ELECTION.—For purposes of sub-
13 paragraph (A), any health insurance coverage
14 with respect to the participant or beneficiary
15 shall be treated as health insurance coverage
16 under a group health plan to which section
17 9801 applies.

18 “(4) CONTRIBUTION AMOUNT.—For purposes
19 of this section, the term ‘contribution amount’
20 means, with respect to an individual under a group
21 health plan, the portion of the applicable premium of
22 such individual under such plan (as determined
23 under section 4980B(f)(4)) which is not paid by the
24 individual. In the case that the employer offers more
25 than one group health plan, the contribution amount

1 shall be the average amount of the applicable pre-
2 miums under such plans.

3 “(5) GROUP HEALTH PLAN.—For purpose of
4 this subsection, subsection (d) shall not apply.

5 “(6) APPLICATION TO FEHBP.—Notwith-
6 standing any other provision of law, the Office of
7 Personnel Management shall carry out the health
8 benefits program under chapter 89 of title 5, United
9 States Code, consistent with the requirements of this
10 subsection.”.

11 (b) REQUIREMENT OF EQUAL CONTRIBUTIONS TO
12 ALL FEHBP PLANS.—Section 8906 of title 5, United
13 States Code, is amended by adding at the end the fol-
14 lowing new subsection:

15 “(j) Notwithstanding the previous provisions of this
16 section the Office of Personnel Management shall revise
17 the amount of the Government contribution made under
18 this section in a manner so that—

19 “(1) the amount of such contribution does not
20 change based on the health benefits plan in which
21 the individual is enrolled; and

22 “(2) the aggregate amount of such contribu-
23 tions is estimated to be equal to the aggregate
24 amount of such contributions if this subsection did
25 not apply.”.

1 (c) EMPLOYEE RETIREMENT INCOME SECURITY ACT
2 OF 1974 CONFORMING AMENDMENTS.—

3 (1) EXCEPTION FROM HIPAA REQUIREMENTS
4 FOR BENEFITS PROVIDED UNDER HEALTH CARE
5 CONTRIBUTION ELECTION.—Section 732 of the Em-
6 ployee Retirement Income Security Act of 1974 (29
7 U.S.C. 1191a) is amended by adding at the end the
8 following new subsection:

9 “(e) HEALTH CARE CONTRIBUTION ELECTION.—

10 “(1) IN GENERAL.—The requirements of this
11 part shall not apply in the case of health insurance
12 coverage (other than excepted benefits as defined in
13 section 9832(e) of the Internal Revenue Code of
14 1986)—

15 “(A) which is provided to a participant or
16 beneficiary by a health insurance issuer under
17 a group health plan, and

18 “(B) with respect to which the require-
19 ments of paragraphs (2) and (3) are met.

20 “(2) CONTRIBUTION ELECTION.—The require-
21 ment of this paragraph is met with respect to health
22 insurance coverage provided to a participant or ben-
23 eficiary by any health insurance issuer under a
24 group health plan if, under such plan—

1 “(A) the participant may elect such cov-
2 erage for any period of coverage in lieu of
3 health insurance coverage otherwise provided
4 under such plan for such period, and

5 “(B) in the case of such an election, the
6 plan sponsor is required to pay to such issuer
7 for the elected coverage for such period an
8 amount which is not less than the contribution
9 amount for such health insurance coverage oth-
10 erwise provided under such plan for such pe-
11 riod.

12 “(3) PRE-EXISTING CONDITIONS.—

13 “(A) IN GENERAL.—The requirement of
14 this paragraph is met with respect to health in-
15 surance coverage provided to a participant or
16 beneficiary by any health insurance issuer if,
17 under such plan the requirements of section
18 701 are met with respect to the participant or
19 beneficiary.

20 “(B) ENFORCEMENT WITH RESPECT TO
21 INDIVIDUAL ELECTION.—For purposes of sub-
22 paragraph (A), any health insurance coverage
23 with respect to the participant or beneficiary
24 shall be treated as health insurance coverage

1 under a group health plan to which section 701
2 applies.

3 “(4) CONTRIBUTION AMOUNT.—

4 “(A) IN GENERAL.—For purposes of this
5 section, the term ‘contribution amount’ means,
6 with respect to any period of health insurance
7 coverage offered to a participant or beneficiary,
8 the portion of the applicable premium of such
9 participant or beneficiary under such plan
10 which is not paid by such participant or bene-
11 ficiary. In the case that the employer offers
12 more than one group health plan, the contribu-
13 tion amount shall be the average amount of the
14 applicable premiums under such plans.

15 “(B) APPLICABLE PREMIUM.—For pur-
16 poses of subparagraph (A), the term ‘applicable
17 premium’ means, with respect to any period of
18 health insurance coverage of a participant or
19 beneficiary under a group health plan, the cost
20 to the plan for such period of such coverage for
21 similarly situated beneficiaries (without regard
22 to whether such cost is paid by the plan spon-
23 sor or the participant or beneficiary).”.

24 (2) EXEMPTION FROM FIDUCIARY LIABILITY.—

25 Section 404 of such Act (29 U.S.C. 1104) is amend-

1 ed by adding at the end the following new sub-
2 section:

3 “(e) The plan sponsor of a group health plan (as de-
4 fined in section 733(a)) shall not be treated as breaching
5 any of the responsibilities, obligations, or duties imposed
6 upon fiduciaries by this title in the case of any individual
7 who is a participant or beneficiary under such plan solely
8 because of the extent to which the plan sponsor provides,
9 in the case of such individual, some or all of such benefits
10 by means of payment of contribution amounts pursuant
11 to a contribution election under section 732(e), irrespec-
12 tive of the amount or type of benefits that would otherwise
13 be provided to such individual under such plan.”.

14 (d) EXCEPTION FROM HIPAA REQUIREMENTS
15 UNDER IRC FOR BENEFITS PROVIDED UNDER HEALTH
16 CARE CONTRIBUTION ELECTION.—Section 9831 of the
17 Internal Revenue Code of 1986 (relating to general excep-
18 tions) is amended by adding at the end the following new
19 subsection:

20 “(d) HEALTH CARE CONTRIBUTION ELECTION.—

21 “(1) IN GENERAL.—The requirements of this
22 chapter shall not apply in the case of health insur-
23 ance coverage (other than excepted benefits as de-
24 fined in section 9832(c))—

1 “(A) which is provided to a participant or
2 beneficiary by a health insurance issuer under
3 a group health plan, and

4 “(B) with respect to which the require-
5 ments of paragraphs (2) and (3) are met.

6 “(2) CONTRIBUTION ELECTION.—The require-
7 ment of this paragraph is met with respect to health
8 insurance coverage provided to a participant or ben-
9 eficiary by any health insurance issuer under a
10 group health plan if, under such plan—

11 “(A) the participant may elect such cov-
12 erage for any period of coverage in lieu of
13 health insurance coverage otherwise provided
14 under such plan for such period, and

15 “(B) in the case of such an election, the
16 plan sponsor is required to pay to such issuer
17 for the elected coverage for such period an
18 amount which is not less than the contribution
19 amount for such health insurance coverage oth-
20 erwise provided under such plan for such pe-
21 riod.

22 “(3) PRE-EXISTING CONDITIONS.—

23 “(A) IN GENERAL.—The requirement of
24 this paragraph is met with respect to health in-
25 surance coverage provided to a participant or

1 beneficiary by any health insurance issuer if,
2 under such plan the requirements of section
3 9801 are met with respect to the participant or
4 beneficiary.

5 “(B) ENFORCEMENT WITH RESPECT TO
6 INDIVIDUAL ELECTION.—For purposes of sub-
7 paragraph (A), any health insurance coverage
8 with respect to the participant or beneficiary
9 shall be treated as health insurance coverage
10 under a group health plan to which section
11 9801 applies.

12 “(4) CONTRIBUTION AMOUNT.—

13 “(A) IN GENERAL.—For purposes of this
14 subsection, the term ‘contribution amount’
15 means, with respect to any period of health in-
16 surance coverage offered to a participant or
17 beneficiary, the portion of the applicable pre-
18 mium of such participant or beneficiary under
19 such plan which is not paid by such participant
20 or beneficiary. In the case that the employer of-
21 fers more than one group health plan, the con-
22 tribution amount shall be the average amount
23 of the applicable premiums under such plans.

24 “(B) APPLICABLE PREMIUM.—For pur-
25 poses of subparagraph (A), the term ‘applicable

1 premium’ means, with respect to any period of
2 health insurance coverage of a participant or
3 beneficiary under a group health plan, the cost
4 to the plan for such period of such coverage for
5 similarly situated beneficiaries (without regard
6 to whether such cost is paid by the plan spon-
7 sor or the participant or beneficiary).”.

8 (e) EXCEPTION FROM HIPAA REQUIREMENTS
9 UNDER THE PHSA FOR BENEFITS PROVIDED UNDER
10 HEALTH CARE CONTRIBUTION ELECTION.—Section 2721
11 of the Public Health Service Act (42 U.S.C. 300gg–21)
12 is amended—

13 (1) by redesignating subsection (e) as sub-
14 section (f); and

15 (2) by inserting after subsection (d) the fol-
16 lowing new subsection:

17 “(e) HEALTH CARE CONTRIBUTION ELECTION.—

18 “(1) IN GENERAL.—The requirements of sub-
19 parts 1 through 3 shall not apply in the case of
20 health insurance coverage (other than excepted bene-
21 fits as defined in section 9832(c) of the Internal
22 Revenue Code of 1986)—

23 “(A) which is provided to a participant or
24 beneficiary by a health insurance issuer under
25 a group health plan, and

1 “(B) with respect to which the require-
2 ments of paragraphs (2) and (3) are met.

3 “(2) CONTRIBUTION ELECTION.—The require-
4 ment of this paragraph is met with respect to health
5 insurance coverage provided to a participant or ben-
6 eficiary by any health insurance issuer under a
7 group health plan if, under such plan—

8 “(A) the participant may elect such cov-
9 erage for any period of coverage in lieu of
10 health insurance coverage otherwise provided
11 under such plan for such period, and

12 “(B) in the case of such an election, the
13 plan sponsor is required to pay to such issuer
14 for the elected coverage for such period an
15 amount which is not less than the contribution
16 amount for such health insurance coverage oth-
17 erwise provided under such plan for such pe-
18 riod.

19 “(3) PRE-EXISTING CONDITIONS.—

20 “(A) IN GENERAL.—The requirement of
21 this paragraph is met with respect to health in-
22 surance coverage provided to a participant or
23 beneficiary by any health insurance issuer if,
24 under such plan the requirements of section

1 2701 are met with respect to the participant or
2 beneficiary.

3 “(B) ENFORCEMENT WITH RESPECT TO
4 INDIVIDUAL ELECTION.—For purposes of sub-
5 paragraph (A), any health insurance coverage
6 with respect to the participant or beneficiary
7 shall be treated as health insurance coverage
8 under a group health plan to which section
9 2701 applies.

10 “(4) CONTRIBUTION AMOUNT.—

11 “(A) IN GENERAL.—For purposes of this
12 section, the term ‘contribution amount’ means,
13 with respect to any period of health insurance
14 coverage offered to a participant or beneficiary,
15 the portion of the applicable premium of such
16 participant or beneficiary under such plan
17 which is not paid by such participant or bene-
18 ficiary. In the case that the employer offers
19 more than one group health plan, the contribu-
20 tion amount shall be the average amount of the
21 applicable premiums under such plans.

22 “(B) APPLICABLE PREMIUM.—For pur-
23 poses of subparagraph (A), the term ‘applicable
24 premium’ means, with respect to any period of
25 health insurance coverage of a participant or

1 beneficiary under a group health plan, the cost
2 to the plan for such period of such coverage for
3 similarly situated beneficiaries (without regard
4 to whether such cost is paid by the plan spon-
5 sor or the participant or beneficiary).”.

6 **SEC. 108. LIMITATIONS ON STATE RESTRICTIONS ON EM-**
7 **PLOYER AUTO-ENROLLMENT.**

8 (a) IN GENERAL.—No State shall establish a law
9 that prevents an employer that is allowed an exclusion
10 from gross income, a deduction, or a credit for Federal
11 income tax purposes for health benefits furnished to a par-
12 ticipant or beneficiary from instituting auto-enrollment
13 which meets the requirements of subsection (b) for cov-
14 erage of a participant or beneficiary under a group health
15 plan, or health insurance coverage offered in connection
16 with such a plan, so long as the participant or beneficiary
17 has the option of declining such coverage.

18 (b) AUTOMATIC ENROLLMENT FOR EMPLOYER-
19 SPONSORED HEALTH BENEFITS.—

20 (1) IN GENERAL.—The requirement of this sub-
21 section with respect to an employer and an employee
22 is that the employer automatically enroll such em-
23 ployee into the employment-based health benefits
24 plan for individual coverage under the plan option
25 with the lowest applicable employee premium.

1 (2) OPT-OUT.—In no case may an employer
2 automatically enroll an employee in a plan under
3 paragraph (1) if such employee makes an affirmative
4 election to opt-out of such plan or to elect coverage
5 under an employment-based health benefits plan of-
6 fered by such employer. An employer shall provide
7 an employee with a 30-day period to make such an
8 affirmative election before the employer may auto-
9 matically enroll the employee in such a plan.

10 (3) NOTICE REQUIREMENTS.—

11 (A) IN GENERAL.—Each employer de-
12 scribed in paragraph (1) who automatically en-
13 rolls an employee into a plan as described in
14 such paragraph shall provide the employees,
15 within a reasonable period before the beginning
16 of each plan year (or, in the case of new em-
17 ployees, within a reasonable period before the
18 end of the enrollment period for such a new em-
19 ployee), written notice of the employees' rights
20 and obligations relating to the automatic enroll-
21 ment requirement under such paragraph. Such
22 notice must be comprehensive and understood
23 by the average employee to whom the automatic
24 enrollment requirement applies.

1 (B) INCLUSION OF SPECIFIC INFORMA-
2 TION.—The written notice under subparagraph
3 (A) must explain an employee’s right to opt out
4 of being automatically enrolled in a plan and in
5 the case that more than one level of benefits or
6 employee premium level is offered by the em-
7 ployer involved, the notice must explain which
8 level of benefits and employee premium level the
9 employee will be automatically enrolled in the
10 absence of an affirmative election by the em-
11 ployee.

12 (c) CONSTRUCTION.—Nothing in this section shall be
13 construed to supersede State law which establishes, imple-
14 ments, or continues in effect any standard or requirement
15 relating to employers in connection with payroll or the
16 sponsoring of employer-sponsored health insurance cov-
17 erage except to the extent that such standard or require-
18 ment prevents an employer from instituting the auto-en-
19 rollment described in subsection (a).

20 (d) NON-APPLICATION TO EXCEPTED BENEFITS.—
21 For purposes of this section, the term “group health plan”
22 does not include excepted benefits (as defined in section
23 2781(c) of the Public Health Service Act (42 U.S.C.
24 300gg–91(c))).

1 **SEC. 109. CREDIT FOR SMALL EMPLOYERS ADOPTING**
2 **AUTO-ENROLLMENT AND DEFINED CON-**
3 **TRIBUTION OPTIONS.**

4 (a) IN GENERAL.—Subpart D of part IV of sub-
5 chapter A of chapter 1 of the Internal Revenue Code of
6 1986, as amended by section 2, is amended by adding at
7 the end the following new section:

8 **“SEC. 45R. AUTO-ENROLLMENT AND DEFINED CONTRIBU-**
9 **TION OPTION FOR HEALTH BENEFITS PLANS**
10 **OF SMALL EMPLOYERS.**

11 “(a) IN GENERAL.—For purposes of section 38, in
12 the case of a small employer, the health benefits plan im-
13 plementation credit determined under this section for the
14 taxable year is an amount equal to 100 percent of the
15 amount paid or incurred by the taxpayer during the tax-
16 able year for qualified health benefits expenses.

17 “(b) LIMITATION.—The credit determined under sub-
18 section (a) with respect to any taxpayer for any taxable
19 year shall not exceed the excess of—

20 “(1) \$1,500, over

21 “(2) sum of the credits determined under sub-
22 section (a) with respect to such taxpayer for all pre-
23 ceding taxable years.

24 “(c) QUALIFIED HEALTH BENEFITS EXPENSES.—
25 For purposes of this section, the term ‘qualified health
26 benefits auto-enrollment expenses’ means, with respect to

1 any taxable year, amounts paid or incurred by the tax-
2 payer during such taxable year for—

3 “(1) establishing auto-enrollment which meets
4 the requirements of section 107 of the Empowering
5 Patients First Act of 2013 for coverage of a partici-
6 pant or beneficiary under a group health plan, or
7 health insurance coverage offered in connection with
8 such a plan, and

9 “(2) implementing the employer contribution
10 option for health insurance coverage pursuant to
11 section 5000(e)(2).

12 “(d) QUALIFIED SMALL EMPLOYER.—For purposes
13 of this section, the term ‘qualified small employer’ means
14 any employer for any taxable year if the number of em-
15 ployees employed by such employer during such taxable
16 year does not exceed 50. All employers treated as a single
17 employer under section (a) or (b) of section 52 shall be
18 treated as a single employer for purposes of this section.

19 “(e) NO DOUBLE BENEFIT.—No deduction or credit
20 shall be allowed under any other provision of this chapter
21 with respect to the amount of the credit determined under
22 this section.

23 “(f) TERMINATION.—Subsection (a) shall not apply
24 to any taxable year beginning after the date which is 2
25 years after the date of the enactment of this section.”.

1 (b) CREDIT TO BE PART OF GENERAL BUSINESS
2 CREDIT.—Subsection (b) of section 38 of such Code, as
3 amended by section 2, is amended by striking “plus” at
4 the end of paragraph (34), by striking the period at the
5 end of paragraph (35) and inserting “, plus”, and by add-
6 ing at the end the following new paragraph:

7 “(36) in the case of a small employer (as de-
8 fined in section 45R(d)), the health benefits plan im-
9 plementation credit determined under section
10 45R(a).”.

11 (c) CLERICAL AMENDMENT.—The table of sections
12 for subpart D of part IV of subchapter A of chapter 1
13 of such Code, as amended by section 2, is amended by
14 inserting after the item relating to section 45Q the fol-
15 lowing new item:

“Sec. 45R. Auto-enrollment and defined contribution option for health benefits
plans of small employers.”.

16 (d) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to taxable years beginning after
18 the date of the enactment of this Act.

19 **SEC. 110. HSA MODIFICATIONS AND CLARIFICATIONS.**

20 (a) CLARIFICATION OF TREATMENT OF CAPITATED
21 PRIMARY CARE PAYMENTS AS AMOUNTS PAID FOR MED-
22 ICAL CARE.—Section 213(d) of the Internal Revenue Code
23 of 1986 (relating to definitions) is amended by adding at
24 the end the following new paragraph:

1 “(12) TREATMENT OF CAPITATED PRIMARY
2 CARE PAYMENTS.—Capitated primary care payments
3 shall be treated as amounts paid for medical care.”.

4 (b) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR
5 VETERANS OR INDIAN HEALTH BENEFITS.—Section
6 223(c)(1) of such Code (defining eligible individual) is
7 amended by adding at the end the following new subpara-
8 graph:

9 “(C) SPECIAL RULE FOR INDIVIDUALS ELI-
10 GIBLE FOR VETERANS OR INDIAN HEALTH BEN-
11 EFITS.—For purposes of subparagraph (A)(ii),
12 an individual shall not be treated as covered
13 under a health plan described in such subpara-
14 graph merely because the individual receives
15 periodic hospital care or medical services under
16 any law administered by the Secretary of Vet-
17 erans Affairs or the Bureau of Indian Affairs.”.

18 (c) CERTAIN PHYSICIAN FEES TO BE TREATED AS
19 MEDICAL CARE.—Section 213(d) of such Code is amend-
20 ed by adding at the end the following new paragraph:

21 “(13) PRE-PAID PHYSICIAN FEES.—The term
22 ‘medical care’ shall include amounts paid by patients
23 to their primary physician in advance for the right
24 to receive medical services on an as-needed basis.”.

1 (d) APPLICATION TO HEALTH CARE SHARING MIN-
 2 ISTRIES.—Section 223 of such Code is amended by adding
 3 at the end the following new subsection:

4 “(i) APPLICATION TO HEALTH CARE SHARING MIN-
 5 ISTRIES.—For purposes of this section, membership in a
 6 health care sharing ministry (as defined in section
 7 36B(f)(3)) shall be treated as coverage under a high de-
 8 ductible health plan.”.

9 (e) EFFECTIVE DATE.—The amendment made by
 10 this section shall apply to taxable years beginning after
 11 the date of the enactment of this Act.

12 **TITLE II—HEALTH INSURANCE**
 13 **POOLING MECHANISMS FOR**
 14 **INDIVIDUALS**

15 **Subtitle A—Federal Grants for**
 16 **State Insurance Expenditures**

17 **SEC. 201. FEDERAL GRANTS FOR STATE INSURANCE EX-**
 18 **PENDITURES.**

19 (a) IN GENERAL.—Subject to the succeeding provi-
 20 sions of this section, each State shall receive from the Sec-
 21 retary of Health and Human Services (in this subtitle re-
 22 ferred to as the “Secretary”) a grant for the State’s pro-
 23 viding for the use, in connection with providing health ben-
 24 efits coverage, of a qualifying high-risk pool or a reinsur-
 25 ance pool or other risk-adjustment mechanism used for

1 the purpose of subsidizing the purchase of private health
2 insurance.

3 (b) FUNDING AMOUNT.—

4 (1) IN GENERAL.—There are hereby appro-
5 priated, out of any funds in the Treasury not other-
6 wise appropriated, \$300,000,000 for each of fiscal
7 years 2014, 2015, and 2016 for grants under this
8 section. Such amount shall be divided among the
9 States as determined by the Secretary.

10 (2) CONSTRUCTION.—Nothing in this section
11 shall be construed as preventing a State from using
12 funding under section 2745 of the Public Health
13 Service Act for purposes of funding reinsurance or
14 other risk mechanisms.

15 (c) LIMITATION.—Funding under subsection (a) may
16 only be used for the following:

17 (1) QUALIFYING HIGH-RISK POOLS.—

18 (A) CURRENT POOLS.—A qualifying high-
19 risk pool created before the date of the enact-
20 ment of this Act that only cover high-risk popu-
21 lations and individuals (and their spouse and
22 dependents) receiving a health care tax credit
23 under section 35 of the Internal Revenue Code
24 of 1986 for a limited period of time as deter-

1 mined by the Secretary or under section 2741
2 of Public Health Service Act.

3 (B) NEW POOLS.—A qualifying high-risk
4 pool created on or after such date that only cov-
5 ers populations and individuals described in
6 subparagraph (A) if the pool—

7 (i) offers at least the option of one or
8 more high-deductible plan options, in com-
9 bination with a contribution into a health
10 savings account;

11 (ii) offers multiple competing health
12 plan options; and

13 (iii) covers only high-risk populations.

14 (2) RISK INSURANCE POOL OR OTHER RISK-AD-
15 JUSTMENT MECHANISMS.—

16 (A) CURRENT REINSURANCE.—A reinsur-
17 ance pool, or other risk-adjustment mechanism,
18 created before the date of the enactment of this
19 Act that only covers populations and individuals
20 described in paragraph (1)(A).

21 (B) NEW POOLS.—A reinsurance pool or
22 other risk-adjustment mechanism created on or
23 after such date that provides reinsurance only
24 covers populations and individuals described in
25 paragraph (1)(A) and only on a prospective

1 basis under which a health insurance issuer
2 cedes covered lives to the pool in exchange for
3 payment of a reinsurance premium.

4 (3) TRANSITION.—Nothing in this section shall
5 be construed as preventing a State from using funds
6 available to transition from an existing high-risk
7 pool to a reinsurance pool.

8 (d) BONUS PAYMENTS.—With respect to any
9 amounts made available to the States under this section,
10 the Secretary shall set aside a portion of such amounts
11 that shall only be available for the following activities by
12 such States:

13 (1) Providing guaranteed availability of indi-
14 vidual health insurance coverage to certain individ-
15 uals with prior group coverage under part B of title
16 XXVII of the Public Health Service Act.

17 (2) A reduction in premium trends, actual pre-
18 miums, or other cost-sharing requirements.

19 (3) An expansion or broadening of the pool of
20 high-risk individuals eligible for coverage.

21 (4) States that adopt the Model Health Plan
22 for Uninsurable Individuals Act of the National As-
23 sociation of Insurance Commissioners (if and when
24 updated by such Association).

1 The Secretary may request such Association to update
2 such Model Health Plan as needed by 2015.

3 (e) ADMINISTRATION.—The Secretary shall provide
4 for the administration of this section and may establish
5 such terms and conditions, including the requirement of
6 an application, as may be appropriate to carry out this
7 section.

8 (f) CONSTRUCTION.—Nothing in this section shall be
9 construed as requiring a State to operate a reinsurance
10 pool (or other risk-adjustment mechanism) under this sec-
11 tion or as preventing a State from operating such a pool
12 or mechanism through one or more private entities.

13 (g) DEFINITIONS.—In this section:

14 (1) QUALIFYING HIGH-RISK POOL.—The term
15 “qualifying high-risk pool” means any qualified
16 high-risk pool (as defined in subsection (g)(1)(A) of
17 section 2745 of the Public Health Service Act) that
18 meets the conditions to receive a grant under section
19 (b)(1) of such section.

20 (2) REINSURANCE POOL OR OTHER RISK-AD-
21 JUSTMENT MECHANISM DEFINED.—The term “rein-
22 surance pool or other risk-adjustment mechanism”
23 means any State-based risk spreading mechanism to
24 subsidize the purchase of private health insurance
25 for the high-risk population.

1 (3) HIGH-RISK POPULATION.—The term “high-
2 risk population” means—

3 (A) individuals who, by reason of the exist-
4 ence or history of a medical condition, are able
5 to acquire health coverage only at rates which
6 are at least 150 percent of the standard risk
7 rates for such coverage (in a non-community-
8 rated non-guaranteed issue State), and

9 (B) individuals who are provided health
10 coverage by a high-risk pool.

11 (4) STATE DEFINED.—The term “State” in-
12 cludes the District of Columbia, Puerto Rico, the
13 Virgin Islands, Guam, American Samoa, and the
14 Northern Mariana Islands.

15 (h) EXTENDING FUNDING.—Section 2745(d)(2) of
16 the Public Health Service Act (42 U.S.C. 300gg–45(d)(2))
17 is amended—

18 (1) in the heading, by inserting “AND 2014
19 THROUGH 2016” after “2010”; and

20 (2) by inserting “and for each of fiscal years
21 2014 through 2016” after “for each of fiscal years
22 2007 through 2010”.

23 (i) SUNSET.—Funds made available under this sec-
24 tion shall not be used for the purpose of subsidizing the

1 purchase of private health insurance on or after October
2 1, 2016.

3 **Subtitle B—Health Care Access and**
4 **Availability**

5 **SEC. 211. EXPANSION OF ACCESS AND CHOICE THROUGH**
6 **INDIVIDUAL AND SMALL EMPLOYER MEM-**
7 **BERSHIP ASSOCIATIONS (IMAS).**

8 The Public Health Service Act, as amended by sec-
9 tion 2, is further amended by inserting after title XXX
10 the following new title:

11 **“TITLE XXXI—INDIVIDUAL AND**
12 **SMALL EMPLOYER MEMBER-**
13 **SHIP ASSOCIATIONS**

14 **“SEC. 3101. DEFINITION OF INDIVIDUAL AND SMALL EM-**
15 **PLOYER MEMBERSHIP ASSOCIATION (IMA).**

16 “(a) IN GENERAL.—For purposes of this title, the
17 terms ‘individual and small employer membership associa-
18 tion’ and ‘IMA’ mean a legal entity that meets the fol-
19 lowing requirements:

20 “(1) ORGANIZATION.—The IMA is an organiza-
21 tion operated under the direction of an association
22 (as defined in section 3104(1)).

23 “(2) OFFERING HEALTH BENEFITS COV-
24 ERAGE.—

1 “(A) DIFFERENT GROUPS.—The IMA, in
2 conjunction with those health insurance issuers
3 that offer health benefits coverage through the
4 IMA, makes available health benefits coverage
5 in the manner described in subsection (b) to all
6 members of the IMA and the dependents of
7 such members (and, in the case of small em-
8 ployers, employees and their dependents) in the
9 manner described in subsection (c)(2) at rates
10 that are established by the health insurance
11 issuer on a policy or product specific basis and
12 that may vary only as permissible under State
13 law.

14 “(B) NONDISCRIMINATION IN COVERAGE
15 OFFERED.—

16 “(i) IN GENERAL.—Subject to clause
17 (ii), the IMA may not offer health benefits
18 coverage to a member of an IMA unless
19 the same coverage is offered to all such
20 members of the IMA.

21 “(ii) CONSTRUCTION.—Nothing in
22 this title shall be construed as requiring or
23 permitting a health insurance issuer to
24 provide coverage outside the service area of
25 the issuer, as approved under State law, or

1 requiring a health insurance issuer from
2 excluding or limiting the coverage on any
3 individual, subject to the requirement of
4 section 2741.

5 “(C) NO FINANCIAL UNDERWRITING.—The
6 IMA provides health benefits coverage only
7 through contracts with health insurance issuers
8 and does not assume insurance risk with re-
9 spect to such coverage.

10 “(3) GEOGRAPHIC AREAS.—Nothing in this title
11 shall be construed as preventing the establishment
12 and operation of more than one IMA in a geographic
13 area or as limiting the number of IMAs that may
14 operate in any area.

15 “(4) PROVISION OF ADMINISTRATIVE SERVICES
16 TO PURCHASERS.—

17 “(A) IN GENERAL.—The IMA may provide
18 administrative services for members. Such serv-
19 ices may include accounting, billing, and enroll-
20 ment information.

21 “(B) CONSTRUCTION.—Nothing in this
22 subsection shall be construed as preventing an
23 IMA from serving as an administrative service
24 organization to any entity.

1 “(5) FILING INFORMATION.—The IMA files
2 with the Secretary information that demonstrates
3 the IMA’s compliance with the applicable require-
4 ments of this title.

5 “(b) HEALTH BENEFITS COVERAGE REQUIRE-
6 MENTS.—

7 “(1) COMPLIANCE WITH CONSUMER PROTEC-
8 TION REQUIREMENTS.—Any health benefits coverage
9 offered through an IMA shall—

10 “(A) be underwritten by a health insurance
11 issuer that—

12 “(i) is licensed (or otherwise regu-
13 lated) under State law, and

14 “(ii) meets all applicable State stand-
15 ards relating to consumer protection, sub-
16 ject to section 3102(b), and

17 “(B) subject to paragraph (2), be approved
18 or otherwise permitted to be offered under
19 State law.

20 “(2) EXAMPLES OF TYPES OF COVERAGE.—The
21 benefits coverage made available through an IMA
22 may include, but is not limited to, any of the fol-
23 lowing if it meets the other applicable requirements
24 of this title:

1 “(A) Coverage through a health mainte-
2 nance organization.

3 “(B) Coverage in connection with a pre-
4 ferred provider organization.

5 “(C) Coverage in connection with a li-
6 censed provider-sponsored organization.

7 “(D) Indemnity coverage through an insur-
8 ance company.

9 “(E) Coverage offered in connection with a
10 contribution into a medical savings account or
11 flexible spending account.

12 “(F) Coverage that includes a point-of-
13 service option.

14 “(G) Any combination of such types of
15 coverage.

16 “(3) WELLNESS BONUSES FOR HEALTH PRO-
17 MOTION.—Nothing in this title shall be construed as
18 precluding a health insurance issuer offering health
19 benefits coverage through an IMA from establishing
20 premium discounts or rebates for members or from
21 modifying otherwise applicable copayments or
22 deductibles in return for adherence to programs of
23 health promotion and disease prevention so long as
24 such programs are agreed to in advance by the IMA
25 and comply with all other provisions of this title and

1 do not discriminate among similarly situated mem-
2 bers.

3 “(c) MEMBERS; HEALTH INSURANCE ISSUERS.—

4 “(1) MEMBERS.—

5 “(A) IN GENERAL.—Under rules estab-
6 lished to carry out this title, with respect to an
7 individual or small employer who is a member
8 of an IMA, the individual may enroll for health
9 benefits coverage (including coverage for de-
10 pendants of such individual) or employer may
11 enroll employees for health benefits coverage
12 (including coverage for dependents of such em-
13 ployees) offered by a health insurance issuer
14 through the IMA.

15 “(B) RULES FOR ENROLLMENT.—Nothing
16 in this paragraph shall preclude an IMA from
17 establishing rules of enrollment and reenroll-
18 ment of members. Such rules shall be applied
19 consistently to all members within the IMA and
20 shall not be based in any manner on health sta-
21 tus-related factors.

22 “(2) HEALTH INSURANCE ISSUERS.—The con-
23 tract between an IMA and a health insurance issuer
24 shall provide, with respect to a member enrolled with
25 health benefits coverage offered by the issuer

1 through the IMA, for the payment of the premiums
2 collected by the issuer.

3 **“SEC. 3102. APPLICATION OF CERTAIN LAWS AND REQUIRE-**
4 **MENTS.**

5 “State laws insofar as they relate to any of the fol-
6 lowing are superseded and shall not apply to health bene-
7 fits coverage made available through an IMA:

8 “(1) Benefit requirements for health benefits
9 coverage offered through an IMA, including (but not
10 limited to) requirements relating to coverage of spe-
11 cific providers, specific services or conditions, or the
12 amount, duration, or scope of benefits, but not in-
13 cluding requirements to the extent required to imple-
14 ment title XXVII or other Federal law and to the
15 extent the requirement prohibits an exclusion of a
16 specific disease from such coverage.

17 “(2) Any other requirements (including limita-
18 tions on compensation arrangements) that, directly
19 or indirectly, preclude (or have the effect of pre-
20 cluding) the offering of such coverage through an
21 IMA, if the IMA meets the requirements of this
22 title.

23 Any State law or regulation relating to the composition
24 or organization of an IMA is preempted to the extent the

1 law or regulation is inconsistent with the provisions of this
2 title.

3 **“SEC. 3103. ADMINISTRATION.**

4 “(a) IN GENERAL.—The Secretary shall administer
5 this title and is authorized to issue such regulations as
6 may be required to carry out this title. Such regulations
7 shall be subject to Congressional review under the provi-
8 sions of chapter 8 of title 5, United States Code. The Sec-
9 retary shall incorporate the process of ‘deemed file and
10 use’ with respect to the information filed under section
11 3101(a)(5)(A) and shall determine whether information
12 filed by an IMA demonstrates compliance with the applica-
13 ble requirements of this title. The Secretary shall exercise
14 authority under this title in a manner that fosters and
15 promotes the development of IMAs in order to improve
16 access to health care coverage and services.

17 “(b) PERIODIC REPORTS.—The Secretary shall sub-
18 mit to Congress a report every 30 months, during the 10-
19 year period beginning on the effective date of the rules
20 promulgated by the Secretary to carry out this title, on
21 the effectiveness of this title in promoting coverage of un-
22 insured individuals. The Secretary may provide for the
23 production of such reports through one or more contracts
24 with appropriate private entities.

1 **“SEC. 3104. DEFINITIONS.**

2 “For purposes of this title:

3 “(1) ASSOCIATION.—The term ‘association’
4 means, with respect to health insurance coverage of-
5 fered in a State, a legal entity which—

6 “(A) has been actively in existence for at
7 least 5 years;

8 “(B) has been formed and maintained in
9 good faith for purposes other than obtaining in-
10 surance;

11 “(C) does not condition membership in the
12 association on any health status-related factor
13 relating to an individual (including an employee
14 of an employer or a dependent of an employee);
15 and

16 “(D) does not make health insurance cov-
17 erage offered through the association available
18 other than in connection with a member of the
19 association.

20 “(2) DEPENDENT.—The term ‘dependent’, as
21 applied to health insurance coverage offered by a
22 health insurance issuer licensed (or otherwise regu-
23 lated) in a State, shall have the meaning applied to
24 such term with respect to such coverage under the
25 laws of the State relating to such coverage and such

1 an issuer. Such term may include the spouse and
2 children of the individual involved.

3 “(3) HEALTH BENEFITS COVERAGE.—The term
4 ‘health benefits coverage’ has the meaning given the
5 term health insurance coverage in section
6 2791(b)(1), and does not include excepted benefits
7 (as defined in section 2791(c)).

8 “(4) HEALTH INSURANCE ISSUER.—The term
9 ‘health insurance issuer’ has the meaning given such
10 term in section 2791(b)(2).

11 “(5) HEALTH STATUS-RELATED FACTOR.—The
12 term ‘health status-related factor’ has the meaning
13 given such term in section 2791(d)(9).

14 “(6) IMA; INDIVIDUAL AND SMALL EMPLOYER
15 MEMBERSHIP ASSOCIATION.—The terms ‘IMA’ and
16 ‘individual and small employer membership associa-
17 tion’ are defined in section 3101(a).

18 “(7) MEMBER.—The term ‘member’ means,
19 with respect to an IMA, an individual or small em-
20 ployer who is a member of the association to which
21 the IMA is offering coverage.

22 “(8) SMALL EMPLOYER.—The term ‘small em-
23 ployer’ has the meaning given such term in section
24 812(a)(13) of the Employee Retirement and Income
25 Security Act of 1974.”

1 **Subtitle C—Small Business Health**
2 **Fairness**

3 **SEC. 221. SHORT TITLE.**

4 This subtitle may be cited as the “Small Business
5 Health Fairness Act of 2013”.

6 **SEC. 222. RULES GOVERNING ASSOCIATION HEALTH**
7 **PLANS.**

8 (a) **IN GENERAL.**—Subtitle B of title I of the Em-
9 ployee Retirement Income Security Act of 1974 is amend-
10 ed by adding after part 7 the following new part:

11 **“PART 8—RULES GOVERNING ASSOCIATION**
12 **HEALTH PLANS**

13 **“SEC. 801. ASSOCIATION HEALTH PLANS.**

14 “(a) **IN GENERAL.**—For purposes of this part, the
15 term ‘association health plan’ means a group health plan
16 whose sponsor is (or is deemed under this part to be) de-
17 scribed in subsection (b).

18 “(b) **SPONSORSHIP.**—The sponsor of a group health
19 plan is described in this subsection if such sponsor—

20 “(1) is organized and maintained in good faith,
21 with a constitution and bylaws specifically stating its
22 purpose and providing for periodic meetings on at
23 least an annual basis, as a bona fide trade associa-
24 tion, a bona fide industry association (including a
25 rural electric cooperative association or a rural tele-

1 phone cooperative association), a bona fide profes-
2 sional association, or a bona fide chamber of com-
3 merce (or similar bona fide business association, in-
4 cluding a corporation or similar organization that
5 operates on a cooperative basis (within the meaning
6 of section 1381 of the Internal Revenue Code of
7 1986)), for substantial purposes other than that of
8 obtaining or providing medical care;

9 “(2) is established as a permanent entity which
10 receives the active support of its members and re-
11 quires for membership payment on a periodic basis
12 of dues or payments necessary to maintain eligibility
13 for membership in the sponsor; and

14 “(3) does not condition membership, such dues
15 or payments, or coverage under the plan on the
16 basis of health status-related factors with respect to
17 the employees of its members (or affiliated mem-
18 bers), or the dependents of such employees, and does
19 not condition such dues or payments on the basis of
20 group health plan participation.

21 Any sponsor consisting of an association of entities which
22 meet the requirements of paragraphs (1), (2), and (3)
23 shall be deemed to be a sponsor described in this sub-
24 section.

1 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**
2 **PLANS.**

3 “(a) IN GENERAL.—The applicable authority shall
4 prescribe by regulation a procedure under which, subject
5 to subsection (b), the applicable authority shall certify as-
6 sociation health plans which apply for certification as
7 meeting the requirements of this part.

8 “(b) STANDARDS.—Under the procedure prescribed
9 pursuant to subsection (a), in the case of an association
10 health plan that provides at least one benefit option which
11 does not consist of health insurance coverage, the applica-
12 ble authority shall certify such plan as meeting the re-
13 quirements of this part only if the applicable authority is
14 satisfied that the applicable requirements of this part are
15 met (or, upon the date on which the plan is to commence
16 operations, will be met) with respect to the plan.

17 “(c) REQUIREMENTS APPLICABLE TO CERTIFIED
18 PLANS.—An association health plan with respect to which
19 certification under this part is in effect shall meet the ap-
20 plicable requirements of this part, effective on the date
21 of certification (or, if later, on the date on which the plan
22 is to commence operations).

23 “(d) REQUIREMENTS FOR CONTINUED CERTIFI-
24 CATION.—The applicable authority may provide by regula-
25 tion for continued certification of association health plans
26 under this part.

1 “(e) CLASS CERTIFICATION FOR FULLY INSURED
2 PLANS.—The applicable authority shall establish a class
3 certification procedure for association health plans under
4 which all benefits consist of health insurance coverage.
5 Under such procedure, the applicable authority shall pro-
6 vide for the granting of certification under this part to
7 the plans in each class of such association health plans
8 upon appropriate filing under such procedure in connec-
9 tion with plans in such class and payment of the pre-
10 scribed fee under section 807(a).

11 “(f) CERTIFICATION OF SELF-INSURED ASSOCIATION
12 HEALTH PLANS.—An association health plan which offers
13 one or more benefit options which do not consist of health
14 insurance coverage may be certified under this part only
15 if such plan consists of any of the following:

16 “(1) a plan which offered such coverage on the
17 date of the enactment of the Small Business Health
18 Fairness Act of 2013,

19 “(2) a plan under which the sponsor does not
20 restrict membership to one or more trades and busi-
21 nesses or industries and whose eligible participating
22 employers represent a broad cross-section of trades
23 and businesses or industries, or

24 “(3) a plan whose eligible participating employ-
25 ers represent one or more trades or businesses, or

1 one or more industries, consisting of any of the fol-
2 lowing: agriculture; equipment and automobile deal-
3 erships; barbering and cosmetology; certified public
4 accounting practices; child care; construction; dance,
5 theatrical and orchestra productions; disinfecting
6 and pest control; financial services; fishing; food
7 service establishments; hospitals; labor organiza-
8 tions; logging; manufacturing (metals); mining; med-
9 ical and dental practices; medical laboratories; pro-
10 fessional consulting services; sanitary services; trans-
11 portation (local and freight); warehousing; whole-
12 saling/distributing; or any other trade or business or
13 industry which has been indicated as having average
14 or above-average risk or health claims experience by
15 reason of State rate filings, denials of coverage, pro-
16 posed premium rate levels, or other means dem-
17 onstrated by such plan in accordance with regula-
18 tions.

19 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**
20 **BOARDS OF TRUSTEES.**

21 “(a) SPONSOR.—The requirements of this subsection
22 are met with respect to an association health plan if the
23 sponsor has met (or is deemed under this part to have
24 met) the requirements of section 801(b) for a continuous

1 period of not less than 3 years ending with the date of
2 the application for certification under this part.

3 “(b) BOARD OF TRUSTEES.—The requirements of
4 this subsection are met with respect to an association
5 health plan if the following requirements are met:

6 “(1) FISCAL CONTROL.—The plan is operated,
7 pursuant to a trust agreement, by a board of trust-
8 ees which has complete fiscal control over the plan
9 and which is responsible for all operations of the
10 plan.

11 “(2) RULES OF OPERATION AND FINANCIAL
12 CONTROLS.—The board of trustees has in effect
13 rules of operation and financial controls, based on a
14 3-year plan of operation, adequate to carry out the
15 terms of the plan and to meet all requirements of
16 this title applicable to the plan.

17 “(3) RULES GOVERNING RELATIONSHIP TO
18 PARTICIPATING EMPLOYERS AND TO CONTRAC-
19 TORS.—

20 “(A) BOARD MEMBERSHIP.—

21 “(i) IN GENERAL.—Except as pro-
22 vided in clauses (ii) and (iii), the members
23 of the board of trustees are individuals se-
24 lected from individuals who are the owners,
25 officers, directors, or employees of the par-

1 participating employers or who are partners in
2 the participating employers and actively
3 participate in the business.

4 “(ii) LIMITATION.—

5 “(I) GENERAL RULE.—Except as
6 provided in subclauses (II) and (III),
7 no such member is an owner, officer,
8 director, or employee of, or partner in,
9 a contract administrator or other
10 service provider to the plan.

11 “(II) LIMITED EXCEPTION FOR
12 PROVIDERS OF SERVICES SOLELY ON
13 BEHALF OF THE SPONSOR.—Officers
14 or employees of a sponsor which is a
15 service provider (other than a contract
16 administrator) to the plan may be
17 members of the board if they con-
18 stitute not more than 25 percent of
19 the membership of the board and they
20 do not provide services to the plan
21 other than on behalf of the sponsor.

22 “(III) TREATMENT OF PRO-
23 VIDERS OF MEDICAL CARE.—In the
24 case of a sponsor which is an associa-
25 tion whose membership consists pri-

1 marily of providers of medical care,
2 subclause (I) shall not apply in the
3 case of any service provider described
4 in subclause (I) who is a provider of
5 medical care under the plan.

6 “(iii) CERTAIN PLANS EXCLUDED.—
7 Clause (i) shall not apply to an association
8 health plan which is in existence on the
9 date of the enactment of the Small Busi-
10 ness Health Fairness Act of 2013.

11 “(B) SOLE AUTHORITY.—The board has
12 sole authority under the plan to approve appli-
13 cations for participation in the plan and to con-
14 tract with a service provider to administer the
15 day-to-day affairs of the plan.

16 “(c) TREATMENT OF FRANCHISE NETWORKS.—In
17 the case of a group health plan which is established and
18 maintained by a franchiser for a franchise network con-
19 sisting of its franchisees—

20 “(1) the requirements of subsection (a) and sec-
21 tion 801(a) shall be deemed met if such require-
22 ments would otherwise be met if the franchiser were
23 deemed to be the sponsor referred to in section
24 801(b), such network were deemed to be an associa-
25 tion described in section 801(b), and each franchisee

1 were deemed to be a member (of the association and
2 the sponsor) referred to in section 801(b); and

3 “(2) the requirements of section 804(a)(1) shall
4 be deemed met.

5 The Secretary may by regulation define for purposes of
6 this subsection the terms ‘franchiser’, ‘franchise network’,
7 and ‘franchisee’.

8 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**
9 **MENTS.**

10 “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The
11 requirements of this subsection are met with respect to
12 an association health plan if, under the terms of the
13 plan—

14 “(1) each participating employer must be—

15 “(A) a member of the sponsor,

16 “(B) the sponsor, or

17 “(C) an affiliated member of the sponsor

18 with respect to which the requirements of sub-

19 section (b) are met,

20 except that, in the case of a sponsor which is a pro-

21 fessional association or other individual-based asso-

22 ciation, if at least one of the officers, directors, or

23 employees of an employer, or at least one of the in-

24 dividuals who are partners in an employer and who

25 actively participates in the business, is a member or

1 such an affiliated member of the sponsor, partici-
2 pating employers may also include such employer;
3 and

4 “(2) all individuals commencing coverage under
5 the plan after certification under this part must
6 be—

7 “(A) active or retired owners (including
8 self-employed individuals), officers, directors, or
9 employees of, or partners in, participating em-
10 ployers; or

11 “(B) the beneficiaries of individuals de-
12 scribed in subparagraph (A).

13 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
14 PLOYEES.—In the case of an association health plan in
15 existence on the date of the enactment of the Small Busi-
16 ness Health Fairness Act of 2013, an affiliated member
17 of the sponsor of the plan may be offered coverage under
18 the plan as a participating employer only if—

19 “(1) the affiliated member was an affiliated
20 member on the date of certification under this part;
21 or

22 “(2) during the 12-month period preceding the
23 date of the offering of such coverage, the affiliated
24 member has not maintained or contributed to a
25 group health plan with respect to any of its employ-

1 ees who would otherwise be eligible to participate in
2 such association health plan.

3 “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-
4 quirements of this subsection are met with respect to an
5 association health plan if, under the terms of the plan,
6 no participating employer may provide health insurance
7 coverage in the individual market for any employee not
8 covered under the plan which is similar to the coverage
9 contemporaneously provided to employees of the employer
10 under the plan, if such exclusion of the employee from cov-
11 erage under the plan is based on a health status-related
12 factor with respect to the employee and such employee
13 would, but for such exclusion on such basis, be eligible
14 for coverage under the plan.

15 “(d) PROHIBITION OF DISCRIMINATION AGAINST
16 EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICI-
17 PATE.—The requirements of this subsection are met with
18 respect to an association health plan if—

19 “(1) under the terms of the plan, all employers
20 meeting the preceding requirements of this section
21 are eligible to qualify as participating employers for
22 all geographically available coverage options, unless,
23 in the case of any such employer, participation or
24 contribution requirements of the type referred to in

1 section 2711 of the Public Health Service Act are
2 not met;

3 “(2) upon request, any employer eligible to par-
4 ticipate is furnished information regarding all cov-
5 erage options available under the plan; and

6 “(3) the applicable requirements of sections
7 701, 702, and 703 are met with respect to the plan.

8 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**
9 **DOCUMENTS, CONTRIBUTION RATES, AND**
10 **BENEFIT OPTIONS.**

11 “(a) IN GENERAL.—The requirements of this section
12 are met with respect to an association health plan if the
13 following requirements are met:

14 “(1) CONTENTS OF GOVERNING INSTRU-
15 MENTS.—The instruments governing the plan in-
16 clude a written instrument, meeting the require-
17 ments of an instrument required under section
18 402(a)(1), which—

19 “(A) provides that the board of trustees
20 serves as the named fiduciary required for plans
21 under section 402(a)(1) and serves in the ca-
22 pacity of a plan administrator (referred to in
23 section 3(16)(A));

1 “(B) provides that the sponsor of the plan
2 is to serve as plan sponsor (referred to in sec-
3 tion 3(16)(B)); and

4 “(C) incorporates the requirements of sec-
5 tion 806.

6 “(2) CONTRIBUTION RATES MUST BE NON-
7 DISCRIMINATORY.—

8 “(A) The contribution rates for any par-
9 ticipating small employer do not vary on the
10 basis of any health status-related factor in rela-
11 tion to employees of such employer or their
12 beneficiaries and do not vary on the basis of the
13 type of business or industry in which such em-
14 ployer is engaged.

15 “(B) Nothing in this title or any other pro-
16 vision of law shall be construed to preclude an
17 association health plan, or a health insurance
18 issuer offering health insurance coverage in
19 connection with an association health plan,
20 from—

21 “(i) setting contribution rates based
22 on the claims experience of the plan; or

23 “(ii) varying contribution rates for
24 small employers in a State to the extent
25 that such rates could vary using the same

1 methodology employed in such State for
2 regulating premium rates in the small
3 group market with respect to health insur-
4 ance coverage offered in connection with
5 bona fide associations (within the meaning
6 of section 2791(d)(3) of the Public Health
7 Service Act),

8 subject to the requirements of section 702(b)
9 relating to contribution rates.

10 “(3) FLOOR FOR NUMBER OF COVERED INDI-
11 VIDUALS WITH RESPECT TO CERTAIN PLANS.—If
12 any benefit option under the plan does not consist
13 of health insurance coverage, the plan has as of the
14 beginning of the plan year not fewer than 1,000 par-
15 ticipants and beneficiaries.

16 “(4) MARKETING REQUIREMENTS.—

17 “(A) IN GENERAL.—If a benefit option
18 which consists of health insurance coverage is
19 offered under the plan, State-licensed insurance
20 agents shall be used to distribute to small em-
21 ployers coverage which does not consist of
22 health insurance coverage in a manner com-
23 parable to the manner in which such agents are
24 used to distribute health insurance coverage.

1 “(B) STATE-LICENSED INSURANCE
2 AGENTS.—For purposes of subparagraph (A),
3 the term ‘State-licensed insurance agents’
4 means one or more agents who are licensed in
5 a State and are subject to the laws of such
6 State relating to licensure, qualification, test-
7 ing, examination, and continuing education of
8 persons authorized to offer, sell, or solicit
9 health insurance coverage in such State.

10 “(5) REGULATORY REQUIREMENTS.—Such
11 other requirements as the applicable authority deter-
12 mines are necessary to carry out the purposes of this
13 part, which shall be prescribed by the applicable au-
14 thority by regulation.

15 “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO
16 DESIGN BENEFIT OPTIONS.—Subject to section 514(d),
17 nothing in this part or any provision of State law (as de-
18 fined in section 514(c)(1)) shall be construed to preclude
19 an association health plan, or a health insurance issuer
20 offering health insurance coverage in connection with an
21 association health plan, from exercising its sole discretion
22 in selecting the specific items and services consisting of
23 medical care to be included as benefits under such plan
24 or coverage, except (subject to section 514) in the case
25 of (1) any law to the extent that it is not preempted under

1 section 731(a)(1) with respect to matters governed by sec-
2 tion 711, 712, or 713, or (2) any law of the State with
3 which filing and approval of a policy type offered by the
4 plan was initially obtained to the extent that such law pro-
5 hibits an exclusion of a specific disease from such cov-
6 erage.

7 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**
8 **FOR SOLVENCY FOR PLANS PROVIDING**
9 **HEALTH BENEFITS IN ADDITION TO HEALTH**
10 **INSURANCE COVERAGE.**

11 “(a) IN GENERAL.—The requirements of this section
12 are met with respect to an association health plan if—

13 “(1) the benefits under the plan consist solely
14 of health insurance coverage; or

15 “(2) if the plan provides any additional benefit
16 options which do not consist of health insurance cov-
17 erage, the plan—

18 “(A) establishes and maintains reserves
19 with respect to such additional benefit options,
20 in amounts recommended by the qualified
21 health actuary, consisting of—

22 “(i) a reserve sufficient for unearned
23 contributions;

24 “(ii) a reserve sufficient for benefit li-
25 abilities which have been incurred, which

1 have not been satisfied, and for which risk
2 of loss has not yet been transferred, and
3 for expected administrative costs with re-
4 spect to such benefit liabilities;

5 “(iii) a reserve sufficient for any other
6 obligations of the plan; and

7 “(iv) a reserve sufficient for a margin
8 of error and other fluctuations, taking into
9 account the specific circumstances of the
10 plan; and

11 “(B) establishes and maintains aggregate
12 and specific excess/stop loss insurance and sol-
13 vency indemnification, with respect to such ad-
14 ditional benefit options for which risk of loss
15 has not yet been transferred, as follows:

16 “(i) The plan shall secure aggregate
17 excess/stop loss insurance for the plan with
18 an attachment point which is not greater
19 than 125 percent of expected gross annual
20 claims. The applicable authority may by
21 regulation provide for upward adjustments
22 in the amount of such percentage in speci-
23 fied circumstances in which the plan spe-
24 cifically provides for and maintains re-

1 serves in excess of the amounts required
2 under subparagraph (A).

3 “(ii) The plan shall secure specific ex-
4 cess/stop loss insurance for the plan with
5 an attachment point which is at least equal
6 to an amount recommended by the plan’s
7 qualified health actuary. The applicable
8 authority may by regulation provide for ad-
9 justments in the amount of such insurance
10 in specified circumstances in which the
11 plan specifically provides for and maintains
12 reserves in excess of the amounts required
13 under subparagraph (A).

14 “(iii) The plan shall secure indem-
15 nification insurance for any claims which
16 the plan is unable to satisfy by reason of
17 a plan termination.

18 Any person issuing to a plan insurance described in clause
19 (i), (ii), or (iii) of subparagraph (B) shall notify the Sec-
20 retary of any failure of premium payment meriting can-
21 cellation of the policy prior to undertaking such a cancella-
22 tion. Any regulations prescribed by the applicable author-
23 ity pursuant to clause (i) or (ii) of subparagraph (B) may
24 allow for such adjustments in the required levels of excess/
25 stop loss insurance as the qualified health actuary may

1 recommend, taking into account the specific circumstances
2 of the plan.

3 “(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS
4 RESERVES.—In the case of any association health plan de-
5 scribed in subsection (a)(2), the requirements of this sub-
6 section are met if the plan establishes and maintains sur-
7 plus in an amount at least equal to—

8 “(1) \$500,000, or

9 “(2) such greater amount (but not greater than
10 \$2,000,000) as may be set forth in regulations pre-
11 scribed by the applicable authority, considering the
12 level of aggregate and specific excess/stop loss insur-
13 ance provided with respect to such plan and other
14 factors related to solvency risk, such as the plan’s
15 projected levels of participation or claims, the nature
16 of the plan’s liabilities, and the types of assets avail-
17 able to assure that such liabilities are met.

18 “(c) ADDITIONAL REQUIREMENTS.—In the case of
19 any association health plan described in subsection (a)(2),
20 the applicable authority may provide such additional re-
21 quirements relating to reserves, excess/stop loss insurance,
22 and indemnification insurance as the applicable authority
23 considers appropriate. Such requirements may be provided
24 by regulation with respect to any such plan or any class
25 of such plans.

1 “(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-
2 ANCE.—The applicable authority may provide for adjust-
3 ments to the levels of reserves otherwise required under
4 subsections (a) and (b) with respect to any plan or class
5 of plans to take into account excess/stop loss insurance
6 provided with respect to such plan or plans.

7 “(e) ALTERNATIVE MEANS OF COMPLIANCE.—The
8 applicable authority may permit an association health plan
9 described in subsection (a)(2) to substitute, for all or part
10 of the requirements of this section (except subsection
11 (a)(2)(B)(iii)), such security, guarantee, hold-harmless ar-
12 rangement, or other financial arrangement as the applica-
13 ble authority determines to be adequate to enable the plan
14 to fully meet all its financial obligations on a timely basis
15 and is otherwise no less protective of the interests of par-
16 ticipants and beneficiaries than the requirements for
17 which it is substituted. The applicable authority may take
18 into account, for purposes of this subsection, evidence pro-
19 vided by the plan or sponsor which demonstrates an as-
20 sumption of liability with respect to the plan. Such evi-
21 dence may be in the form of a contract of indemnification,
22 lien, bonding, insurance, letter of credit, recourse under
23 applicable terms of the plan in the form of assessments
24 of participating employers, security, or other financial ar-
25 rangement.

1 “(f) MEASURES TO ENSURE CONTINUED PAYMENT
2 OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

3 “(1) PAYMENTS BY CERTAIN PLANS TO ASSO-
4 CIATION HEALTH PLAN FUND.—

5 “(A) IN GENERAL.—In the case of an as-
6 sociation health plan described in subsection
7 (a)(2), the requirements of this subsection are
8 met if the plan makes payments into the Asso-
9 ciation Health Plan Fund under this subpara-
10 graph when they are due. Such payments shall
11 consist of annual payments in the amount of
12 \$5,000, and, in addition to such annual pay-
13 ments, such supplemental payments as the Sec-
14 retary may determine to be necessary under
15 paragraph (2). Payments under this paragraph
16 are payable to the Fund at the time determined
17 by the Secretary. Initial payments are due in
18 advance of certification under this part. Pay-
19 ments shall continue to accrue until a plan’s as-
20 sets are distributed pursuant to a termination
21 procedure.

22 “(B) PENALTIES FOR FAILURE TO MAKE
23 PAYMENTS.—If any payment is not made by a
24 plan when it is due, a late payment charge of
25 not more than 100 percent of the payment

1 which was not timely paid shall be payable by
2 the plan to the Fund.

3 “(C) CONTINUED DUTY OF THE SEC-
4 RETARY.—The Secretary shall not cease to
5 carry out the provisions of paragraph (2) on ac-
6 count of the failure of a plan to pay any pay-
7 ment when due.

8 “(2) PAYMENTS BY SECRETARY TO CONTINUE
9 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
10 DEMNFICATION INSURANCE COVERAGE FOR CER-
11 TAIN PLANS.—In any case in which the applicable
12 authority determines that there is, or that there is
13 reason to believe that there will be: (A) a failure to
14 take necessary corrective actions under section
15 809(a) with respect to an association health plan de-
16 scribed in subsection (a)(2); or (B) a termination of
17 such a plan under section 809(b) or 810(b)(8) (and,
18 if the applicable authority is not the Secretary, cer-
19 tifies such determination to the Secretary), the Sec-
20 retary shall determine the amounts necessary to
21 make payments to an insurer (designated by the
22 Secretary) to maintain in force excess/stop loss in-
23 surance coverage or indemnification insurance cov-
24 erage for such plan, if the Secretary determines that
25 there is a reasonable expectation that, without such

1 payments, claims would not be satisfied by reason of
2 termination of such coverage. The Secretary shall, to
3 the extent provided in advance in appropriation
4 Acts, pay such amounts so determined to the insurer
5 designated by the Secretary.

6 “(3) ASSOCIATION HEALTH PLAN FUND.—

7 “(A) IN GENERAL.—There is established
8 on the books of the Treasury a fund to be
9 known as the ‘Association Health Plan Fund’.
10 The Fund shall be available for making pay-
11 ments pursuant to paragraph (2). The Fund
12 shall be credited with payments received pursu-
13 ant to paragraph (1)(A), penalties received pur-
14 suant to paragraph (1)(B), and earnings on in-
15 vestments of amounts of the Fund under sub-
16 paragraph (B).

17 “(B) INVESTMENT.—Whenever the Sec-
18 retary determines that the moneys of the fund
19 are in excess of current needs, the Secretary
20 may request the investment of such amounts as
21 the Secretary determines advisable by the Sec-
22 retary of the Treasury in obligations issued or
23 guaranteed by the United States.

24 “(g) EXCESS/STOP LOSS INSURANCE.—For purposes
25 of this section—

1 “(1) AGGREGATE EXCESS/STOP LOSS INSUR-
2 ANCE.—The term ‘aggregate excess/stop loss insur-
3 ance’ means, in connection with an association
4 health plan, a contract—

5 “(A) under which an insurer (meeting such
6 minimum standards as the applicable authority
7 may prescribe by regulation) provides for pay-
8 ment to the plan with respect to aggregate
9 claims under the plan in excess of an amount
10 or amounts specified in such contract;

11 “(B) which is guaranteed renewable; and

12 “(C) which allows for payment of pre-
13 miums by any third party on behalf of the in-
14 sured plan.

15 “(2) SPECIFIC EXCESS/STOP LOSS INSUR-
16 ANCE.—The term ‘specific excess/stop loss insur-
17 ance’ means, in connection with an association
18 health plan, a contract—

19 “(A) under which an insurer (meeting such
20 minimum standards as the applicable authority
21 may prescribe by regulation) provides for pay-
22 ment to the plan with respect to claims under
23 the plan in connection with a covered individual
24 in excess of an amount or amounts specified in

1 such contract in connection with such covered
2 individual;

3 “(B) which is guaranteed renewable; and

4 “(C) which allows for payment of pre-
5 miums by any third party on behalf of the in-
6 sured plan.

7 “(h) INDEMNIFICATION INSURANCE.—For purposes
8 of this section, the term ‘indemnification insurance’
9 means, in connection with an association health plan, a
10 contract—

11 “(1) under which an insurer (meeting such min-
12 imum standards as the applicable authority may pre-
13 scribe by regulation) provides for payment to the
14 plan with respect to claims under the plan which the
15 plan is unable to satisfy by reason of a termination
16 pursuant to section 809(b) (relating to mandatory
17 termination);

18 “(2) which is guaranteed renewable and
19 noncancellable for any reason (except as the applica-
20 ble authority may prescribe by regulation); and

21 “(3) which allows for payment of premiums by
22 any third party on behalf of the insured plan.

23 “(i) RESERVES.—For purposes of this section, the
24 term ‘reserves’ means, in connection with an association
25 health plan, plan assets which meet the fiduciary stand-

1 ards under part 4 and such additional requirements re-
2 garding liquidity as the applicable authority may prescribe
3 by regulation.

4 “(j) SOLVENCY STANDARDS WORKING GROUP.—

5 “(1) IN GENERAL.—Within 90 days after the
6 date of the enactment of the Small Business Health
7 Fairness Act of 2013, the applicable authority shall
8 establish a Solvency Standards Working Group. In
9 prescribing the initial regulations under this section,
10 the applicable authority shall take into account the
11 recommendations of such Working Group.

12 “(2) MEMBERSHIP.—The Working Group shall
13 consist of not more than 15 members appointed by
14 the applicable authority. The applicable authority
15 shall include among persons invited to membership
16 on the Working Group at least one of each of the
17 following:

18 “(A) A representative of the National As-
19 sociation of Insurance Commissioners.

20 “(B) A representative of the American
21 Academy of Actuaries.

22 “(C) A representative of the State govern-
23 ments, or their interests.

24 “(D) A representative of existing self-in-
25 sured arrangements, or their interests.

1 “(E) A representative of associations of
2 the type referred to in section 801(b)(1), or
3 their interests.

4 “(F) A representative of multiemployer
5 plans that are group health plans, or their in-
6 terests.

7 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**
8 **LATED REQUIREMENTS.**

9 “(a) **FILING FEE.**—Under the procedure prescribed
10 pursuant to section 802(a), an association health plan
11 shall pay to the applicable authority at the time of filing
12 an application for certification under this part a filing fee
13 in the amount of \$5,000, which shall be available in the
14 case of the Secretary, to the extent provided in appropria-
15 tion Acts, for the sole purpose of administering the certifi-
16 cation procedures applicable with respect to association
17 health plans.

18 “(b) **INFORMATION TO BE INCLUDED IN APPLICA-**
19 **TION FOR CERTIFICATION.**—An application for certifi-
20 cation under this part meets the requirements of this sec-
21 tion only if it includes, in a manner and form which shall
22 be prescribed by the applicable authority by regulation, at
23 least the following information:

24 “(1) **IDENTIFYING INFORMATION.**—The names
25 and addresses of—

1 “(A) the sponsor; and

2 “(B) the members of the board of trustees
3 of the plan.

4 “(2) STATES IN WHICH PLAN INTENDS TO DO
5 BUSINESS.—The States in which participants and
6 beneficiaries under the plan are to be located and
7 the number of them expected to be located in each
8 such State.

9 “(3) BONDING REQUIREMENTS.—Evidence pro-
10 vided by the board of trustees that the bonding re-
11 quirements of section 412 will be met as of the date
12 of the application or (if later) commencement of op-
13 erations.

14 “(4) PLAN DOCUMENTS.—A copy of the docu-
15 ments governing the plan (including any bylaws and
16 trust agreements), the summary plan description,
17 and other material describing the benefits that will
18 be provided to participants and beneficiaries under
19 the plan.

20 “(5) AGREEMENTS WITH SERVICE PRO-
21 VIDERS.—A copy of any agreements between the
22 plan and contract administrators and other service
23 providers.

24 “(6) FUNDING REPORT.—In the case of asso-
25 ciation health plans providing benefits options in ad-

1 dition to health insurance coverage, a report setting
2 forth information with respect to such additional
3 benefit options determined as of a date within the
4 120-day period ending with the date of the applica-
5 tion, including the following:

6 “(A) RESERVES.—A statement, certified
7 by the board of trustees of the plan, and a
8 statement of actuarial opinion, signed by a
9 qualified health actuary, that all applicable re-
10 quirements of section 806 are or will be met in
11 accordance with regulations which the applica-
12 ble authority shall prescribe.

13 “(B) ADEQUACY OF CONTRIBUTION
14 RATES.—A statement of actuarial opinion,
15 signed by a qualified health actuary, which sets
16 forth a description of the extent to which con-
17 tribution rates are adequate to provide for the
18 payment of all obligations and the maintenance
19 of required reserves under the plan for the 12-
20 month period beginning with such date within
21 such 120-day period, taking into account the
22 expected coverage and experience of the plan. If
23 the contribution rates are not fully adequate,
24 the statement of actuarial opinion shall indicate

1 the extent to which the rates are inadequate
2 and the changes needed to ensure adequacy.

3 “(C) CURRENT AND PROJECTED VALUE OF
4 ASSETS AND LIABILITIES.—A statement of ac-
5 tuarial opinion signed by a qualified health ac-
6 tuary, which sets forth the current value of the
7 assets and liabilities accumulated under the
8 plan and a projection of the assets, liabilities,
9 income, and expenses of the plan for the 12-
10 month period referred to in subparagraph (B).
11 The income statement shall identify separately
12 the plan’s administrative expenses and claims.

13 “(D) COSTS OF COVERAGE TO BE
14 CHARGED AND OTHER EXPENSES.—A state-
15 ment of the costs of coverage to be charged, in-
16 cluding an itemization of amounts for adminis-
17 tration, reserves, and other expenses associated
18 with the operation of the plan.

19 “(E) OTHER INFORMATION.—Any other
20 information as may be determined by the appli-
21 cable authority, by regulation, as necessary to
22 carry out the purposes of this part.

23 “(c) FILING NOTICE OF CERTIFICATION WITH
24 STATES.—A certification granted under this part to an
25 association health plan shall not be effective unless written

1 notice of such certification is filed with the applicable
2 State authority of each State in which at least 25 percent
3 of the participants and beneficiaries under the plan are
4 located. For purposes of this subsection, an individual
5 shall be considered to be located in the State in which a
6 known address of such individual is located or in which
7 such individual is employed.

8 “(d) NOTICE OF MATERIAL CHANGES.—In the case
9 of any association health plan certified under this part,
10 descriptions of material changes in any information which
11 was required to be submitted with the application for the
12 certification under this part shall be filed in such form
13 and manner as shall be prescribed by the applicable au-
14 thority by regulation. The applicable authority may re-
15 quire by regulation prior notice of material changes with
16 respect to specified matters which might serve as the basis
17 for suspension or revocation of the certification.

18 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-
19 SOCIATION HEALTH PLANS.—An association health plan
20 certified under this part which provides benefit options in
21 addition to health insurance coverage for such plan year
22 shall meet the requirements of section 103 by filing an
23 annual report under such section which shall include infor-
24 mation described in subsection (b)(6) with respect to the
25 plan year and, notwithstanding section 104(a)(1)(A), shall

1 be filed with the applicable authority not later than 90
2 days after the close of the plan year (or on such later date
3 as may be prescribed by the applicable authority). The ap-
4 plicable authority may require by regulation such interim
5 reports as it considers appropriate.

6 “(f) ENGAGEMENT OF QUALIFIED HEALTH ACTU-
7 ARY.—The board of trustees of each association health
8 plan which provides benefits options in addition to health
9 insurance coverage and which is applying for certification
10 under this part or is certified under this part shall engage,
11 on behalf of all participants and beneficiaries, a qualified
12 health actuary who shall be responsible for the preparation
13 of the materials comprising information necessary to be
14 submitted by a qualified health actuary under this part.
15 The qualified health actuary shall utilize such assumptions
16 and techniques as are necessary to enable such actuary
17 to form an opinion as to whether the contents of the mat-
18 ters reported under this part—

19 “(1) are in the aggregate reasonably related to
20 the experience of the plan and to reasonable expecta-
21 tions; and

22 “(2) represent such actuary’s best estimate of
23 anticipated experience under the plan.

1 The opinion by the qualified health actuary shall be made
2 with respect to, and shall be made a part of, the annual
3 report.

4 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**
5 **MINATION.**

6 “Except as provided in section 809(b), an association
7 health plan which is or has been certified under this part
8 may terminate (upon or at any time after cessation of ac-
9 cruals in benefit liabilities) only if the board of trustees,
10 not less than 60 days before the proposed termination
11 date—

12 “(1) provides to the participants and bene-
13 ficiaries a written notice of intent to terminate stat-
14 ing that such termination is intended and the pro-
15 posed termination date;

16 “(2) develops a plan for winding up the affairs
17 of the plan in connection with such termination in
18 a manner which will result in timely payment of all
19 benefits for which the plan is obligated; and

20 “(3) submits such plan in writing to the appli-
21 cable authority.

22 Actions required under this section shall be taken in such
23 form and manner as may be prescribed by the applicable
24 authority by regulation.

1 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**
2 **NATION.**

3 “(a) ACTIONS TO AVOID DEPLETION OF RE-
4 SERVES.—An association health plan which is certified
5 under this part and which provides benefits other than
6 health insurance coverage shall continue to meet the re-
7 quirements of section 806, irrespective of whether such
8 certification continues in effect. The board of trustees of
9 such plan shall determine quarterly whether the require-
10 ments of section 806 are met. In any case in which the
11 board determines that there is reason to believe that there
12 is or will be a failure to meet such requirements, or the
13 applicable authority makes such a determination and so
14 notifies the board, the board shall immediately notify the
15 qualified health actuary engaged by the plan, and such
16 actuary shall, not later than the end of the next following
17 month, make such recommendations to the board for cor-
18 rective action as the actuary determines necessary to en-
19 sure compliance with section 806. Not later than 30 days
20 after receiving from the actuary recommendations for cor-
21 rective actions, the board shall notify the applicable au-
22 thority (in such form and manner as the applicable au-
23 thority may prescribe by regulation) of such recommenda-
24 tions of the actuary for corrective action, together with
25 a description of the actions (if any) that the board has
26 taken or plans to take in response to such recommenda-

1 tions. The board shall thereafter report to the applicable
2 authority, in such form and frequency as the applicable
3 authority may specify to the board, regarding corrective
4 action taken by the board until the requirements of section
5 806 are met.

6 “(b) MANDATORY TERMINATION.—In any case in
7 which—

8 “(1) the applicable authority has been notified
9 under subsection (a) (or by an issuer of excess/stop
10 loss insurance or indemnity insurance pursuant to
11 section 806(a)) of a failure of an association health
12 plan which is or has been certified under this part
13 and is described in section 806(a)(2) to meet the re-
14 quirements of section 806 and has not been notified
15 by the board of trustees of the plan that corrective
16 action has restored compliance with such require-
17 ments; and

18 “(2) the applicable authority determines that
19 there is a reasonable expectation that the plan will
20 continue to fail to meet the requirements of section
21 806,

22 the board of trustees of the plan shall, at the direction
23 of the applicable authority, terminate the plan and, in the
24 course of the termination, take such actions as the appli-
25 cable authority may require, including satisfying any

1 claims referred to in section 806(a)(2)(B)(iii) and recov-
2 ering for the plan any liability under subsection
3 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure
4 that the affairs of the plan will be, to the maximum extent
5 possible, wound up in a manner which will result in timely
6 provision of all benefits for which the plan is obligated.

7 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**
8 **VENT ASSOCIATION HEALTH PLANS PRO-**
9 **VIDING HEALTH BENEFITS IN ADDITION TO**
10 **HEALTH INSURANCE COVERAGE.**

11 “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
12 INSOLVENT PLANS.—Whenever the Secretary determines
13 that an association health plan which is or has been cer-
14 tified under this part and which is described in section
15 806(a)(2) will be unable to provide benefits when due or
16 is otherwise in a financially hazardous condition, as shall
17 be defined by the Secretary by regulation, the Secretary
18 shall, upon notice to the plan, apply to the appropriate
19 United States district court for appointment of the Sec-
20 retary as trustee to administer the plan for the duration
21 of the insolvency. The plan may appear as a party and
22 other interested persons may intervene in the proceedings
23 at the discretion of the court. The court shall appoint such
24 Secretary trustee if the court determines that the trustee-
25 ship is necessary to protect the interests of the partici-

1 pants and beneficiaries or providers of medical care or to
2 avoid any unreasonable deterioration of the financial con-
3 dition of the plan. The trusteeship of such Secretary shall
4 continue until the conditions described in the first sen-
5 tence of this subsection are remedied or the plan is termi-
6 nated.

7 “(b) POWERS AS TRUSTEE.—The Secretary, upon
8 appointment as trustee under subsection (a), shall have
9 the power—

10 “(1) to do any act authorized by the plan, this
11 title, or other applicable provisions of law to be done
12 by the plan administrator or any trustee of the plan;

13 “(2) to require the transfer of all (or any part)
14 of the assets and records of the plan to the Sec-
15 retary as trustee;

16 “(3) to invest any assets of the plan which the
17 Secretary holds in accordance with the provisions of
18 the plan, regulations prescribed by the Secretary,
19 and applicable provisions of law;

20 “(4) to require the sponsor, the plan adminis-
21 trator, any participating employer, and any employee
22 organization representing plan participants to fur-
23 nish any information with respect to the plan which
24 the Secretary as trustee may reasonably need in
25 order to administer the plan;

1 “(5) to collect for the plan any amounts due the
2 plan and to recover reasonable expenses of the trust-
3 eeship;

4 “(6) to commence, prosecute, or defend on be-
5 half of the plan any suit or proceeding involving the
6 plan;

7 “(7) to issue, publish, or file such notices, state-
8 ments, and reports as may be required by the Sec-
9 retary by regulation or required by any order of the
10 court;

11 “(8) to terminate the plan (or provide for its
12 termination in accordance with section 809(b)) and
13 liquidate the plan assets, to restore the plan to the
14 responsibility of the sponsor, or to continue the
15 trusteeship;

16 “(9) to provide for the enrollment of plan par-
17 ticipants and beneficiaries under appropriate cov-
18 erage options; and

19 “(10) to do such other acts as may be nec-
20 essary to comply with this title or any order of the
21 court and to protect the interests of plan partici-
22 pants and beneficiaries and providers of medical
23 care.

1 “(c) NOTICE OF APPOINTMENT.—As soon as prac-
2 ticable after the Secretary’s appointment as trustee, the
3 Secretary shall give notice of such appointment to—

4 “(1) the sponsor and plan administrator;

5 “(2) each participant;

6 “(3) each participating employer; and

7 “(4) if applicable, each employee organization
8 which, for purposes of collective bargaining, rep-
9 resents plan participants.

10 “(d) ADDITIONAL DUTIES.—Except to the extent in-
11 consistent with the provisions of this title, or as may be
12 otherwise ordered by the court, the Secretary, upon ap-
13 pointment as trustee under this section, shall be subject
14 to the same duties as those of a trustee under section 704
15 of title 11, United States Code, and shall have the duties
16 of a fiduciary for purposes of this title.

17 “(e) OTHER PROCEEDINGS.—An application by the
18 Secretary under this subsection may be filed notwith-
19 standing the pendency in the same or any other court of
20 any bankruptcy, mortgage foreclosure, or equity receiver-
21 ship proceeding, or any proceeding to reorganize, conserve,
22 or liquidate such plan or its property, or any proceeding
23 to enforce a lien against property of the plan.

24 “(f) JURISDICTION OF COURT.—

1 “(1) IN GENERAL.—Upon the filing of an appli-
2 cation for the appointment as trustee or the issuance
3 of a decree under this section, the court to which the
4 application is made shall have exclusive jurisdiction
5 of the plan involved and its property wherever lo-
6 cated with the powers, to the extent consistent with
7 the purposes of this section, of a court of the United
8 States having jurisdiction over cases under chapter
9 11 of title 11, United States Code. Pending an adju-
10 dication under this section such court shall stay, and
11 upon appointment by it of the Secretary as trustee,
12 such court shall continue the stay of, any pending
13 mortgage foreclosure, equity receivership, or other
14 proceeding to reorganize, conserve, or liquidate the
15 plan, the sponsor, or property of such plan or spon-
16 sor, and any other suit against any receiver, conser-
17 vator, or trustee of the plan, the sponsor, or prop-
18 erty of the plan or sponsor. Pending such adjudica-
19 tion and upon the appointment by it of the Sec-
20 retary as trustee, the court may stay any proceeding
21 to enforce a lien against property of the plan or the
22 sponsor or any other suit against the plan or the
23 sponsor.

24 “(2) VENUE.—An action under this section
25 may be brought in the judicial district where the

1 sponsor or the plan administrator resides or does
2 business or where any asset of the plan is situated.
3 A district court in which such action is brought may
4 issue process with respect to such action in any
5 other judicial district.

6 “(g) PERSONNEL.—In accordance with regulations
7 which shall be prescribed by the Secretary, the Secretary
8 shall appoint, retain, and compensate accountants, actu-
9 aries, and other professional service personnel as may be
10 necessary in connection with the Secretary’s service as
11 trustee under this section.

12 **“SEC. 811. STATE ASSESSMENT AUTHORITY.**

13 “(a) IN GENERAL.—Notwithstanding section 514, a
14 State may impose by law a contribution tax on an associa-
15 tion health plan described in section 806(a)(2), if the plan
16 commenced operations in such State after the date of the
17 enactment of the Small Business Health Fairness Act of
18 2013.

19 “(b) CONTRIBUTION TAX.—For purposes of this sec-
20 tion, the term ‘contribution tax’ imposed by a State on
21 an association health plan means any tax imposed by such
22 State if—

23 “(1) such tax is computed by applying a rate to
24 the amount of premiums or contributions, with re-
25 spect to individuals covered under the plan who are

1 residents of such State, which are received by the
2 plan from participating employers located in such
3 State or from such individuals;

4 “(2) the rate of such tax does not exceed the
5 rate of any tax imposed by such State on premiums
6 or contributions received by insurers or health main-
7 tenance organizations for health insurance coverage
8 offered in such State in connection with a group
9 health plan;

10 “(3) such tax is otherwise nondiscriminatory;
11 and

12 “(4) the amount of any such tax assessed on
13 the plan is reduced by the amount of any tax or as-
14 sessment otherwise imposed by the State on pre-
15 miums, contributions, or both received by insurers or
16 health maintenance organizations for health insur-
17 ance coverage, aggregate excess/stop loss insurance
18 (as defined in section 806(g)(1)), specific excess/stop
19 loss insurance (as defined in section 806(g)(2)),
20 other insurance related to the provision of medical
21 care under the plan, or any combination thereof pro-
22 vided by such insurers or health maintenance organi-
23 zations in such State in connection with such plan.

24 **“SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.**

25 “(a) DEFINITIONS.—For purposes of this part—

1 “(1) GROUP HEALTH PLAN.—The term ‘group
2 health plan’ has the meaning provided in section
3 733(a)(1) (after applying subsection (b) of this sec-
4 tion).

5 “(2) MEDICAL CARE.—The term ‘medical care’
6 has the meaning provided in section 733(a)(2).

7 “(3) HEALTH INSURANCE COVERAGE.—The
8 term ‘health insurance coverage’ has the meaning
9 provided in section 733(b)(1).

10 “(4) HEALTH INSURANCE ISSUER.—The term
11 ‘health insurance issuer’ has the meaning provided
12 in section 733(b)(2).

13 “(5) APPLICABLE AUTHORITY.—The term ‘ap-
14 plicable authority’ means the Secretary, except that,
15 in connection with any exercise of the Secretary’s
16 authority regarding which the Secretary is required
17 under section 506(d) to consult with a State, such
18 term means the Secretary, in consultation with such
19 State.

20 “(6) HEALTH STATUS-RELATED FACTOR.—The
21 term ‘health status-related factor’ has the meaning
22 provided in section 733(d)(2).

23 “(7) INDIVIDUAL MARKET.—

24 “(A) IN GENERAL.—The term ‘individual
25 market’ means the market for health insurance

1 coverage offered to individuals other than in
2 connection with a group health plan.

3 “(B) TREATMENT OF VERY SMALL
4 GROUPS.—

5 “(i) IN GENERAL.—Subject to clause
6 (ii), such term includes coverage offered in
7 connection with a group health plan that
8 has fewer than 2 participants as current
9 employees or participants described in sec-
10 tion 732(d)(3) on the first day of the plan
11 year.

12 “(ii) STATE EXCEPTION.—Clause (i)
13 shall not apply in the case of health insur-
14 ance coverage offered in a State if such
15 State regulates the coverage described in
16 such clause in the same manner and to the
17 same extent as coverage in the small group
18 market (as defined in section 2791(e)(5) of
19 the Public Health Service Act) is regulated
20 by such State.

21 “(8) PARTICIPATING EMPLOYER.—The term
22 ‘participating employer’ means, in connection with
23 an association health plan, any employer, if any indi-
24 vidual who is an employee of such employer, a part-
25 ner in such employer, or a self-employed individual

1 who is such employer (or any dependent, as defined
2 under the terms of the plan, of such individual) is
3 or was covered under such plan in connection with
4 the status of such individual as such an employee,
5 partner, or self-employed individual in relation to the
6 plan.

7 “(9) APPLICABLE STATE AUTHORITY.—The
8 term ‘applicable State authority’ means, with respect
9 to a health insurance issuer in a State, the State in-
10 surance commissioner or official or officials des-
11 ignated by the State to enforce the requirements of
12 title XXVII of the Public Health Service Act for the
13 State involved with respect to such issuer.

14 “(10) QUALIFIED HEALTH ACTUARY.—The
15 term ‘qualified health actuary’ means an individual
16 who is a member of the American Academy of Actu-
17 aries with expertise in health care.

18 “(11) AFFILIATED MEMBER.—The term ‘affili-
19 ated member’ means, in connection with a sponsor—

20 “(A) a person who is otherwise eligible to
21 be a member of the sponsor but who elects an
22 affiliated status with the sponsor,

23 “(B) in the case of a sponsor with mem-
24 bers which consist of associations, a person who

1 is a member of any such association and elects
2 an affiliated status with the sponsor, or

3 “(C) in the case of an association health
4 plan in existence on the date of the enactment
5 of the Small Business Health Fairness Act of
6 2013, a person eligible to be a member of the
7 sponsor or one of its member associations.

8 “(12) LARGE EMPLOYER.—The term ‘large em-
9 ployer’ means, in connection with a group health
10 plan with respect to a plan year, an employer who
11 employed an average of at least 51 employees on
12 business days during the preceding calendar year
13 and who employs at least 2 employees on the first
14 day of the plan year.

15 “(13) SMALL EMPLOYER.—The term ‘small em-
16 ployer’ means, in connection with a group health
17 plan with respect to a plan year, an employer who
18 is not a large employer.

19 “(b) RULES OF CONSTRUCTION.—

20 “(1) EMPLOYERS AND EMPLOYEES.—For pur-
21 poses of determining whether a plan, fund, or pro-
22 gram is an employee welfare benefit plan which is an
23 association health plan, and for purposes of applying
24 this title in connection with such plan, fund, or pro-

1 gram so determined to be such an employee welfare
2 benefit plan—

3 “(A) in the case of a partnership, the term
4 ‘employer’ (as defined in section 3(5)) includes
5 the partnership in relation to the partners, and
6 the term ‘employee’ (as defined in section 3(6))
7 includes any partner in relation to the partner-
8 ship; and

9 “(B) in the case of a self-employed indi-
10 vidual, the term ‘employer’ (as defined in sec-
11 tion 3(5)) and the term ‘employee’ (as defined
12 in section 3(6)) shall include such individual.

13 “(2) PLANS, FUNDS, AND PROGRAMS TREATED
14 AS EMPLOYEE WELFARE BENEFIT PLANS.—In the
15 case of any plan, fund, or program which was estab-
16 lished or is maintained for the purpose of providing
17 medical care (through the purchase of insurance or
18 otherwise) for employees (or their dependents) cov-
19 ered thereunder and which demonstrates to the Sec-
20 retary that all requirements for certification under
21 this part would be met with respect to such plan,
22 fund, or program if such plan, fund, or program
23 were a group health plan, such plan, fund, or pro-
24 gram shall be treated for purposes of this title as an

1 employee welfare benefit plan on and after the date
2 of such demonstration.

3 “(3) EXCEPTION FOR CERTAIN BENEFITS.—
4 The requirements of this part shall not apply to a
5 group health plan in relation to its provision of ex-
6 cepted benefits, as defined in section 706(c).”.

7 (b) CONFORMING AMENDMENTS TO PREEMPTION
8 RULES.—

9 (1) Section 514(b)(6) of such Act (29 U.S.C.
10 1144(b)(6)) is amended by adding at the end the
11 following new subparagraph:

12 “(E) The preceding subparagraphs of this paragraph
13 do not apply with respect to any State law in the case
14 of an association health plan which is certified under part
15 8.”.

16 (2) Section 514 of such Act (29 U.S.C. 1144)
17 is amended—

18 (A) in subsection (b)(4), by striking “Sub-
19 section (a)” and inserting “Subsections (a) and
20 (d)”;

21 (B) in subsection (b)(5), by striking “sub-
22 section (a)” in subparagraph (A) and inserting
23 “subsection (a) of this section and subsections
24 (a)(2)(B) and (b) of section 805”, and by strik-
25 ing “subsection (a)” in subparagraph (B) and

1 inserting “subsection (a) of this section or sub-
2 section (a)(2)(B) or (b) of section 805”;

3 (C) by redesignating subsection (d) as sub-
4 section (e); and

5 (D) by inserting after subsection (c) the
6 following new subsection:

7 “(d)(1) Except as provided in subsection (b)(4), the
8 provisions of this title shall supersede any and all State
9 laws insofar as they may now or hereafter preclude, or
10 have the effect of precluding, a health insurance issuer
11 from offering health insurance coverage in connection with
12 an association health plan which is certified under part
13 8.

14 “(2) Except as provided in paragraphs (4) and (5)
15 of subsection (b) of this section—

16 “(A) In any case in which health insurance cov-
17 erage of any policy type is offered under an associa-
18 tion health plan certified under part 8 to a partici-
19 pating employer operating in such State, the provi-
20 sions of this title shall supersede any and all laws
21 of such State insofar as they may preclude a health
22 insurance issuer from offering health insurance cov-
23 erage of the same policy type to other employers op-
24 erating in the State which are eligible for coverage
25 under such association health plan, whether or not

1 such other employers are participating employers in
2 such plan.

3 “(B) In any case in which health insurance cov-
4 erage of any policy type is offered in a State under
5 an association health plan certified under part 8 and
6 the filing, with the applicable State authority (as de-
7 fined in section 812(a)(9)), of the policy form in
8 connection with such policy type is approved by such
9 State authority, the provisions of this title shall su-
10 percede any and all laws of any other State in which
11 health insurance coverage of such type is offered, in-
12 sofar as they may preclude, upon the filing in the
13 same form and manner of such policy form with the
14 applicable State authority in such other State, the
15 approval of the filing in such other State.

16 “(3) Nothing in subsection (b)(6)(E) or the preceding
17 provisions of this subsection shall be construed, with re-
18 spect to health insurance issuers or health insurance cov-
19 erage, to supersede or impair the law of any State—

20 “(A) providing solvency standards or similar
21 standards regarding the adequacy of insurer capital,
22 surplus, reserves, or contributions, or

23 “(B) relating to prompt payment of claims.

1 “(4) For additional provisions relating to association
2 health plans, see subsections (a)(2)(B) and (b) of section
3 805.

4 “(5) For purposes of this subsection, the term ‘asso-
5 ciation health plan’ has the meaning provided in section
6 801(a), and the terms ‘health insurance coverage’, ‘par-
7 ticipating employer’, and ‘health insurance issuer’ have
8 the meanings provided such terms in section 812, respec-
9 tively.”.

10 (3) Section 514(b)(6)(A) of such Act (29
11 U.S.C. 1144(b)(6)(A)) is amended—

12 (A) in clause (i)(II), by striking “and” at
13 the end;

14 (B) in clause (ii), by inserting “and which
15 does not provide medical care (within the mean-
16 ing of section 733(a)(2)),” after “arrange-
17 ment,”, and by striking “title.” and inserting
18 “title, and”; and

19 (C) by adding at the end the following new
20 clause:

21 “(iii) subject to subparagraph (E), in the case
22 of any other employee welfare benefit plan which is
23 a multiple employer welfare arrangement and which
24 provides medical care (within the meaning of section

1 733(a)(2)), any law of any State which regulates in-
2 surance may apply.”.

3 (4) Section 514(e) of such Act (as redesignated
4 by paragraph (2)(C)) is amended—

5 (A) by striking “Nothing” and inserting
6 “(1) Except as provided in paragraph (2), noth-
7 ing”; and

8 (B) by adding at the end the following new
9 paragraph:

10 “(2) Nothing in any other provision of law enacted
11 on or after the date of the enactment of the Small Busi-
12 ness Health Fairness Act of 2013 shall be construed to
13 alter, amend, modify, invalidate, impair, or supersede any
14 provision of this title, except by specific cross-reference to
15 the affected section.”.

16 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act
17 (29 U.S.C. 102(16)(B)) is amended by adding at the end
18 the following new sentence: “Such term also includes a
19 person serving as the sponsor of an association health plan
20 under part 8.”.

21 (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-
22 LATED TO SELF-INSURED AND FULLY INSURED OPTIONS
23 UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)
24 of such Act (29 U.S.C. 102(b)) is amended by adding at
25 the end the following: “An association health plan shall

1 include in its summary plan description, in connection
 2 with each benefit option, a description of the form of sol-
 3 vency or guarantee fund protection secured pursuant to
 4 this Act or applicable State law, if any.”.

5 (e) SAVINGS CLAUSE.—Section 731(c) of such Act is
 6 amended by inserting “or part 8” after “this part”.

7 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-
 8 CATION OF SELF-INSURED ASSOCIATION HEALTH
 9 PLANS.—Not later than January 1, 2016, the Secretary
 10 of Labor shall report to the Committee on Education and
 11 the Workforce of the House of Representatives and the
 12 Committee on Health, Education, Labor, and Pensions of
 13 the Senate the effect association health plans have had,
 14 if any, on reducing the number of uninsured individuals.

15 (g) CLERICAL AMENDMENT.—The table of contents
 16 in section 1 of the Employee Retirement Income Security
 17 Act of 1974 is amended by inserting after the item relat-
 18 ing to section 734 the following new items:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

- “801. Association health plans.
- “802. Certification of association health plans.
- “803. Requirements relating to sponsors and boards of trustees.
- “804. Participation and coverage requirements.
- “805. Other requirements relating to plan documents, contribution rates, and benefit options.
- “806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
- “807. Requirements for application and related requirements.
- “808. Notice requirements for voluntary termination.
- “809. Corrective actions and mandatory termination.
- “810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

“811. State assessment authority.

“812. Definitions and rules of construction.”.

1 **SEC. 223. CLARIFICATION OF TREATMENT OF SINGLE EM-**
2 **PLOYER ARRANGEMENTS.**

3 Section 3(40)(B) of the Employee Retirement Income
4 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-
5 ed—

6 (1) in clause (i), by inserting after “control
7 group,” the following: “except that, in any case in
8 which the benefit referred to in subparagraph (A)
9 consists of medical care (as defined in section
10 812(a)(2)), two or more trades or businesses, wheth-
11 er or not incorporated, shall be deemed a single em-
12 ployer for any plan year of such plan, or any fiscal
13 year of such other arrangement, if such trades or
14 businesses are within the same control group during
15 such year or at any time during the preceding 1-year
16 period,”;

17 (2) in clause (iii), by striking “(iii) the deter-
18 mination” and inserting the following:

19 “(iii)(I) in any case in which the benefit re-
20 ferred to in subparagraph (A) consists of medical
21 care (as defined in section 812(a)(2)), the deter-
22 mination of whether a trade or business is under
23 ‘common control’ with another trade or business
24 shall be determined under regulations of the Sec-

1 retary applying principles consistent and coextensive
2 with the principles applied in determining whether
3 employees of two or more trades or businesses are
4 treated as employed by a single employer under sec-
5 tion 4001(b), except that, for purposes of this para-
6 graph, an interest of greater than 25 percent may
7 not be required as the minimum interest necessary
8 for common control, or

9 “(II) in any other case, the determination”;

10 (3) by redesignating clauses (iv) and (v) as
11 clauses (v) and (vi), respectively; and

12 (4) by inserting after clause (iii) the following
13 new clause:

14 “(iv) in any case in which the benefit referred
15 to in subparagraph (A) consists of medical care (as
16 defined in section 812(a)(2)), in determining, after
17 the application of clause (i), whether benefits are
18 provided to employees of two or more employers, the
19 arrangement shall be treated as having only one par-
20 ticipating employer if, after the application of clause
21 (i), the number of individuals who are employees and
22 former employees of any one participating employer
23 and who are covered under the arrangement is
24 greater than 75 percent of the aggregate number of
25 all individuals who are employees or former employ-

1 ees of participating employers and who are covered
2 under the arrangement,”.

3 **SEC. 224. ENFORCEMENT PROVISIONS RELATING TO ASSO-**
4 **CIATION HEALTH PLANS.**

5 (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL
6 MISREPRESENTATIONS.—Section 501 of the Employee
7 Retirement Income Security Act of 1974 (29 U.S.C. 1131)
8 is amended—

9 (1) by inserting “(a)” after “Sec. 501.”; and

10 (2) by adding at the end the following new sub-
11 section:

12 “(b) Any person who willfully falsely represents, to
13 any employee, any employee’s beneficiary, any employer,
14 the Secretary, or any State, a plan or other arrangement
15 established or maintained for the purpose of offering or
16 providing any benefit described in section 3(1) to employ-
17 ees or their beneficiaries as—

18 “(1) being an association health plan which has
19 been certified under part 8;

20 “(2) having been established or maintained
21 under or pursuant to one or more collective bar-
22 gaining agreements which are reached pursuant to
23 collective bargaining described in section 8(d) of the
24 National Labor Relations Act (29 U.S.C. 158(d)) or
25 paragraph Fourth of section 2 of the Railway Labor

1 Act (45 U.S.C. 152, paragraph Fourth) or which are
2 reached pursuant to labor-management negotiations
3 under similar provisions of State public employee re-
4 lations laws; or

5 “(3) being a plan or arrangement described in
6 section 3(40)(A)(i),

7 shall, upon conviction, be imprisoned not more than 5
8 years, be fined under title 18, United States Code, or
9 both.”.

10 (b) CEASE ACTIVITIES ORDERS.—Section 502 of
11 such Act (29 U.S.C. 1132) is amended by adding at the
12 end the following new subsection:

13 “(n) ASSOCIATION HEALTH PLAN CEASE AND DE-
14 SIST ORDERS.—

15 “(1) IN GENERAL.—Subject to paragraph (2),
16 upon application by the Secretary showing the oper-
17 ation, promotion, or marketing of an association
18 health plan (or similar arrangement providing bene-
19 fits consisting of medical care (as defined in section
20 733(a)(2))) that—

21 “(A) is not certified under part 8, is sub-
22 ject under section 514(b)(6) to the insurance
23 laws of any State in which the plan or arrange-
24 ment offers or provides benefits, and is not li-

1 censed, registered, or otherwise approved under
2 the insurance laws of such State; or

3 “(B) is an association health plan certified
4 under part 8 and is not operating in accordance
5 with the requirements under part 8 for such
6 certification,

7 a district court of the United States shall enter an
8 order requiring that the plan or arrangement cease
9 activities.

10 “(2) EXCEPTION.—Paragraph (1) shall not
11 apply in the case of an association health plan or
12 other arrangement if the plan or arrangement shows
13 that—

14 “(A) all benefits under it referred to in
15 paragraph (1) consist of health insurance cov-
16 erage; and

17 “(B) with respect to each State in which
18 the plan or arrangement offers or provides ben-
19 efits, the plan or arrangement is operating in
20 accordance with applicable State laws that are
21 not superseded under section 514.

22 “(3) ADDITIONAL EQUITABLE RELIEF.—The
23 court may grant such additional equitable relief, in-
24 cluding any relief available under this title, as it
25 deems necessary to protect the interests of the pub-

1 “(A) the Secretary’s authority under sec-
2 tions 502 and 504 to enforce the requirements
3 for certification under part 8; and

4 “(B) the Secretary’s authority to certify
5 association health plans under part 8 in accord-
6 ance with regulations of the Secretary applica-
7 ble to certification under part 8.

8 “(2) RECOGNITION OF PRIMARY DOMICILE
9 STATE.—In carrying out paragraph (1), the Sec-
10 retary shall ensure that only one State will be recog-
11 nized, with respect to any particular association
12 health plan, as the State with which consultation is
13 required. In carrying out this paragraph—

14 “(A) in the case of a plan which provides
15 health insurance coverage (as defined in section
16 812(a)(3)), such State shall be the State with
17 which filing and approval of a policy type of-
18 fered by the plan was initially obtained, and

19 “(B) in any other case, the Secretary shall
20 take into account the places of residence of the
21 participants and beneficiaries under the plan
22 and the State in which the trust is main-
23 tained.”.

1 **SEC. 226. EFFECTIVE DATE AND TRANSITIONAL AND**
2 **OTHER RULES.**

3 (a) **EFFECTIVE DATE.**—The amendments made by
4 this subtitle shall take effect 1 year after the date of the
5 enactment of this Act. The Secretary of Labor shall first
6 issue all regulations necessary to carry out the amend-
7 ments made by this subtitle within 1 year after the date
8 of the enactment of this Act.

9 (b) **TREATMENT OF CERTAIN EXISTING HEALTH**
10 **BENEFITS PROGRAMS.**—

11 (1) **IN GENERAL.**—In any case in which, as of
12 the date of the enactment of this Act, an arrange-
13 ment is maintained in a State for the purpose of
14 providing benefits consisting of medical care for the
15 employees and beneficiaries of its participating em-
16 ployers, at least 200 participating employers make
17 contributions to such arrangement, such arrange-
18 ment has been in existence for at least 10 years, and
19 such arrangement is licensed under the laws of one
20 or more States to provide such benefits to its par-
21 ticipating employers, upon the filing with the appli-
22 cable authority (as defined in section 812(a)(5) of
23 the Employee Retirement Income Security Act of
24 1974 (as amended by this subtitle)) by the arrange-
25 ment of an application for certification of the ar-

1 arrangement under part 8 of subtitle B of title I of
2 such Act—

3 (A) such arrangement shall be deemed to
4 be a group health plan for purposes of title I
5 of such Act;

6 (B) the requirements of sections 801(a)
7 and 803(a) of the Employee Retirement Income
8 Security Act of 1974 shall be deemed met with
9 respect to such arrangement;

10 (C) the requirements of section 803(b) of
11 such Act shall be deemed met, if the arrange-
12 ment is operated by a board of directors
13 which—

14 (i) is elected by the participating em-
15 ployers, with each employer having one
16 vote; and

17 (ii) has complete fiscal control over
18 the arrangement and which is responsible
19 for all operations of the arrangement;

20 (D) the requirements of section 804(a) of
21 such Act shall be deemed met with respect to
22 such arrangement; and

23 (E) the arrangement may be certified by
24 any applicable authority with respect to its op-

1 erations in any State only if it operates in such
2 State on the date of certification.

3 The provisions of this subsection shall cease to apply
4 with respect to any such arrangement at such time
5 after the date of the enactment of this Act as the
6 applicable requirements of this subsection are not
7 met with respect to such arrangement.

8 (2) DEFINITIONS.—For purposes of this sub-
9 section, the terms “group health plan”, “medical
10 care”, and “participating employer” shall have the
11 meanings provided in section 812 of the Employee
12 Retirement Income Security Act of 1974, except
13 that the reference in paragraph (7) of such section
14 to an “association health plan” shall be deemed a
15 reference to an arrangement referred to in this sub-
16 section.

17 **TITLE III—INTERSTATE MARKET**
18 **FOR HEALTH INSURANCE**

19 **SEC. 301. COOPERATIVE GOVERNING OF INDIVIDUAL**
20 **HEALTH INSURANCE COVERAGE.**

21 (a) IN GENERAL.—Title XXVII of the Public Health
22 Service Act (42 U.S.C. 300gg et seq.), as restored by sec-
23 tion 2, is amended by adding at the end the following new
24 part:

1 **“PART D—COOPERATIVE GOVERNING OF**
2 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

3 **“SEC. 2795. DEFINITIONS.**

4 “In this part:

5 “(1) PRIMARY STATE.—The term ‘primary
6 State’ means, with respect to individual health insur-
7 ance coverage offered by a health insurance issuer,
8 the State designated by the issuer as the State
9 whose covered laws shall govern the health insurance
10 issuer in the sale of such coverage under this part.
11 An issuer, with respect to a particular policy, may
12 only designate one such State as its primary State
13 with respect to all such coverage it offers. Such an
14 issuer may not change the designated primary State
15 with respect to individual health insurance coverage
16 once the policy is issued, except that such a change
17 may be made upon renewal of the policy. With re-
18 spect to such designated State, the issuer is deemed
19 to be doing business in that State.

20 “(2) SECONDARY STATE.—The term ‘secondary
21 State’ means, with respect to individual health insur-
22 ance coverage offered by a health insurance issuer,
23 any State that is not the primary State. In the case
24 of a health insurance issuer that is selling a policy
25 in, or to a resident of, a secondary State, the issuer

1 is deemed to be doing business in that secondary
2 State.

3 “(3) HEALTH INSURANCE ISSUER.—The term
4 ‘health insurance issuer’ has the meaning given such
5 term in section 2791(b)(2), except that such an
6 issuer must be licensed in the primary State and be
7 qualified to sell individual health insurance coverage
8 in that State.

9 “(4) INDIVIDUAL HEALTH INSURANCE COV-
10 ERAGE.—The term ‘individual health insurance cov-
11 erage’ means health insurance coverage offered in
12 the individual market, as defined in section
13 2791(e)(1), but does not include excepted benefits
14 described in section 2791(c).

15 “(5) APPLICABLE STATE AUTHORITY.—The
16 term ‘applicable State authority’ means, with respect
17 to a health insurance issuer in a State, the State in-
18 surance commissioner or official or officials des-
19 ignated by the State to enforce the requirements of
20 this title for the State with respect to the issuer.

21 “(6) HAZARDOUS FINANCIAL CONDITION.—The
22 term ‘hazardous financial condition’ means that,
23 based on its present or reasonably anticipated finan-
24 cial condition, a health insurance issuer is unlikely
25 to be able—

1 “(A) to meet obligations to policyholders
2 with respect to known claims and reasonably
3 anticipated claims; or

4 “(B) to pay other obligations in the normal
5 course of business.

6 “(7) COVERED LAWS.—

7 “(A) IN GENERAL.—The term ‘covered
8 laws’ means the laws, rules, regulations, agree-
9 ments, and orders governing the insurance busi-
10 ness pertaining to—

11 “(i) individual health insurance cov-
12 erage issued by a health insurance issuer;

13 “(ii) the offer, sale, rating (including
14 medical underwriting), renewal, and
15 issuance of individual health insurance cov-
16 erage to an individual;

17 “(iii) the provision to an individual in
18 relation to individual health insurance cov-
19 erage of health care and insurance related
20 services;

21 “(iv) the provision to an individual in
22 relation to individual health insurance cov-
23 erage of management, operations, and in-
24 vestment activities of a health insurance
25 issuer; and

1 “(v) the provision to an individual in
2 relation to individual health insurance cov-
3 erage of loss control and claims adminis-
4 tration for a health insurance issuer with
5 respect to liability for which the issuer pro-
6 vides insurance.

7 “(B) EXCEPTION.—Such term does not in-
8 clude any law, rule, regulation, agreement, or
9 order governing the use of care or cost manage-
10 ment techniques, including any requirement re-
11 lated to provider contracting, network access or
12 adequacy, health care data collection, or quality
13 assurance.

14 “(8) STATE.—The term ‘State’ means only the
15 50 States and the District of Columbia.

16 “(9) UNFAIR CLAIMS SETTLEMENT PRAC-
17 TICES.—The term ‘unfair claims settlement prac-
18 tices’ means only the following practices:

19 “(A) Knowingly misrepresenting to claim-
20 ants and insured individuals relevant facts or
21 policy provisions relating to coverage at issue.

22 “(B) Failing to acknowledge with reason-
23 able promptness pertinent communications with
24 respect to claims arising under policies.

1 “(C) Failing to adopt and implement rea-
2 sonable standards for the prompt investigation
3 and settlement of claims arising under policies.

4 “(D) Failing to effectuate prompt, fair,
5 and equitable settlement of claims submitted in
6 which liability has become reasonably clear.

7 “(E) Refusing to pay claims without con-
8 ducting a reasonable investigation.

9 “(F) Failing to affirm or deny coverage of
10 claims within a reasonable period of time after
11 having completed an investigation related to
12 those claims.

13 “(G) A pattern or practice of compelling
14 insured individuals or their beneficiaries to in-
15 stitute suits to recover amounts due under its
16 policies by offering substantially less than the
17 amounts ultimately recovered in suits brought
18 by them.

19 “(H) A pattern or practice of attempting
20 to settle or settling claims for less than the
21 amount that a reasonable person would believe
22 the insured individual or his or her beneficiary
23 was entitled by reference to written or printed
24 advertising material accompanying or made
25 part of an application.

1 “(I) Attempting to settle or settling claims
2 on the basis of an application that was materi-
3 ally altered without notice to, or knowledge or
4 consent of, the insured.

5 “(J) Failing to provide forms necessary to
6 present claims within 15 calendar days of a re-
7 quests with reasonable explanations regarding
8 their use.

9 “(K) Attempting to cancel a policy in less
10 time than that prescribed in the policy or by the
11 law of the primary State.

12 “(10) FRAUD AND ABUSE.—The term ‘fraud
13 and abuse’ means an act or omission committed by
14 a person who, knowingly and with intent to defraud,
15 commits, or conceals any material information con-
16 cerning, one or more of the following:

17 “(A) Presenting, causing to be presented
18 or preparing with knowledge or belief that it
19 will be presented to or by an insurer, a rein-
20 surer, broker or its agent, false information as
21 part of, in support of or concerning a fact ma-
22 terial to one or more of the following:

23 “(i) An application for the issuance or
24 renewal of an insurance policy or reinsur-
25 ance contract.

1 “(ii) The rating of an insurance policy
2 or reinsurance contract.

3 “(iii) A claim for payment or benefit
4 pursuant to an insurance policy or reinsur-
5 ance contract.

6 “(iv) Premiums paid on an insurance
7 policy or reinsurance contract.

8 “(v) Payments made in accordance
9 with the terms of an insurance policy or
10 reinsurance contract.

11 “(vi) A document filed with the com-
12 missioner or the chief insurance regulatory
13 official of another jurisdiction.

14 “(vii) The financial condition of an in-
15 surer or reinsurer.

16 “(viii) The formation, acquisition,
17 merger, reconsolidation, dissolution or
18 withdrawal from one or more lines of in-
19 surance or reinsurance in all or part of a
20 State by an insurer or reinsurer.

21 “(ix) The issuance of written evidence
22 of insurance.

23 “(x) The reinstatement of an insur-
24 ance policy.

1 “(B) Solicitation or acceptance of new or
2 renewal insurance risks on behalf of an insurer,
3 reinsurer, or other person engaged in the busi-
4 ness of insurance by a person who knows or
5 should know that the insurer or other person
6 responsible for the risk is insolvent at the time
7 of the transaction.

8 “(C) Transaction of the business of insur-
9 ance in violation of laws requiring a license, cer-
10 tificate of authority or other legal authority for
11 the transaction of the business of insurance.

12 “(D) Attempt to commit, aiding or abet-
13 ting in the commission of, or conspiracy to com-
14 mit the acts or omissions specified in this para-
15 graph.

16 **“SEC. 2796. APPLICATION OF LAW.**

17 “(a) IN GENERAL.—The covered laws of the primary
18 State shall apply to individual health insurance coverage
19 offered by a health insurance issuer in the primary State
20 and in any secondary State, but only if the coverage and
21 issuer comply with the conditions of this section with re-
22 spect to the offering of coverage in any secondary State.

23 “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-
24 ONDARY STATE.—Except as provided in this section, a
25 health insurance issuer with respect to its offer, sale, rat-

1 ing (including medical underwriting), renewal, and
2 issuance of individual health insurance coverage in any
3 secondary State is exempt from any covered laws of the
4 secondary State (and any rules, regulations, agreements,
5 or orders sought or issued by such State under or related
6 to such covered laws) to the extent that such laws would—

7 “(1) make unlawful, or regulate, directly or in-
8 directly, the operation of the health insurance issuer
9 operating in the secondary State, except that any
10 secondary State may require such an issuer—

11 “(A) to pay, on a nondiscriminatory basis,
12 applicable premium and other taxes (including
13 high-risk pool assessments) which are levied on
14 insurers and surplus lines insurers, brokers, or
15 policyholders under the laws of the State;

16 “(B) to register with and designate the
17 State insurance commissioner as its agent solely
18 for the purpose of receiving service of legal doc-
19 uments or process;

20 “(C) to submit to an examination of its fi-
21 nancial condition by the State insurance com-
22 missioner in any State in which the issuer is
23 doing business to determine the issuer’s finan-
24 cial condition, if—

1 “(i) the State insurance commissioner
2 of the primary State has not done an ex-
3 amination within the period recommended
4 by the National Association of Insurance
5 Commissioners; and

6 “(ii) any such examination is con-
7 ducted in accordance with the examiners’
8 handbook of the National Association of
9 Insurance Commissioners and is coordi-
10 nated to avoid unjustified duplication and
11 unjustified repetition;

12 “(D) to comply with a lawful order
13 issued—

14 “(i) in a delinquency proceeding com-
15 menced by the State insurance commis-
16 sioner if there has been a finding of finan-
17 cial impairment under subparagraph (C);
18 or

19 “(ii) in a voluntary dissolution pro-
20 ceeding;

21 “(E) to comply with an injunction issued
22 by a court of competent jurisdiction, upon a pe-
23 tition by the State insurance commissioner al-
24 leging that the issuer is in hazardous financial
25 condition;

1 “(F) to participate, on a nondiscriminatory
2 basis, in any insurance insolvency guaranty as-
3 sociation or similar association to which a
4 health insurance issuer in the State is required
5 to belong;

6 “(G) to comply with any State law regard-
7 ing fraud and abuse (as defined in section
8 2795(10)), except that if the State seeks an in-
9 junction regarding the conduct described in this
10 subparagraph, such injunction must be obtained
11 from a court of competent jurisdiction;

12 “(H) to comply with any State law regard-
13 ing unfair claims settlement practices (as de-
14 fined in section 2795(9)); or

15 “(I) to comply with the applicable require-
16 ments for independent review under section
17 2798 with respect to coverage offered in the
18 State;

19 “(2) require any individual health insurance
20 coverage issued by the issuer to be countersigned by
21 an insurance agent or broker residing in that Sec-
22 ondary State; or

23 “(3) otherwise discriminate against the issuer
24 issuing insurance in both the primary State and in
25 any secondary State.

1 “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A
2 health insurance issuer shall provide the following notice,
3 in 12-point bold type, in any insurance coverage offered
4 in a secondary State under this part by such a health in-
5 surance issuer and at renewal of the policy, with the 5
6 blank spaces therein being appropriately filled with the
7 name of the health insurance issuer, the name of primary
8 State, the name of the secondary State, the name of the
9 secondary State, and the name of the secondary State, re-
10 spectively, for the coverage concerned:

11 This policy is issued by _____ and is governed by
12 the laws and regulations of the State of _____, and
13 it has met all the laws of that State as determined by
14 that State’s Department of Insurance. This policy may be
15 less expensive than others because it is not subject to all
16 of the insurance laws and regulations of the State of
17 _____, including coverage of some services or bene-
18 fits mandated by the law of the State of _____. Ad-
19 ditionally, this policy is not subject to all of the consumer
20 protection laws or restrictions on rate changes of the State
21 of _____. As with all insurance products, before pur-
22 chasing this policy, you should carefully review the policy
23 and determine what health care services the policy covers
24 and what benefits it provides, including any exclusions,
25 limitations, or conditions for such services or benefits.

1 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS
2 AND PREMIUM INCREASES.—

3 “(1) IN GENERAL.—For purposes of this sec-
4 tion, a health insurance issuer that provides indi-
5 vidual health insurance coverage to an individual
6 under this part in a primary or secondary State may
7 not upon renewal—

8 “(A) move or reclassify the individual in-
9 sured under the health insurance coverage from
10 the class such individual is in at the time of
11 issue of the contract based on the health-status
12 related factors of the individual; or

13 “(B) increase the premiums assessed the
14 individual for such coverage based on a health
15 status-related factor or change of a health sta-
16 tus-related factor or the past or prospective
17 claim experience of the insured individual.

18 “(2) CONSTRUCTION.—Nothing in paragraph
19 (1) shall be construed to prohibit a health insurance
20 issuer—

21 “(A) from terminating or discontinuing
22 coverage or a class of coverage in accordance
23 with subsections (b) and (c) of section 2742;

1 “(B) from raising premium rates for all
2 policy holders within a class based on claims ex-
3 perience;

4 “(C) from changing premiums or offering
5 discounted premiums to individuals who engage
6 in wellness activities at intervals prescribed by
7 the issuer, if such premium changes or incen-
8 tives—

9 “(i) are disclosed to the consumer in
10 the insurance contract;

11 “(ii) are based on specific wellness ac-
12 tivities that are not applicable to all indi-
13 viduals; and

14 “(iii) are not obtainable by all individ-
15 uals to whom coverage is offered;

16 “(D) from reinstating lapsed coverage; or

17 “(E) from retroactively adjusting the rates
18 charged an insured individual if the initial rates
19 were set based on material misrepresentation by
20 the individual at the time of issue.

21 “(e) PRIOR OFFERING OF POLICY IN PRIMARY
22 STATE.—A health insurance issuer may not offer for sale
23 individual health insurance coverage in a secondary State
24 unless that coverage is currently offered for sale in the
25 primary State.

1 “(f) LICENSING OF AGENTS OR BROKERS FOR
2 HEALTH INSURANCE ISSUERS.—Any State may require
3 that a person acting, or offering to act, as an agent or
4 broker for a health insurance issuer with respect to the
5 offering of individual health insurance coverage obtain a
6 license from that State, with commissions or other com-
7 pensation subject to the provisions of the laws of that
8 State, except that a State may not impose any qualifica-
9 tion or requirement which discriminates against a non-
10 resident agent or broker.

11 “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-
12 SURANCE COMMISSIONER.—Each health insurance issuer
13 issuing individual health insurance coverage in both pri-
14 mary and secondary States shall submit—

15 “(1) to the insurance commissioner of each
16 State in which it intends to offer such coverage, be-
17 fore it may offer individual health insurance cov-
18 erage in such State—

19 “(A) a copy of the plan of operation or fea-
20 sibility study or any similar statement of the
21 policy being offered and its coverage (which
22 shall include the name of its primary State and
23 its principal place of business);

24 “(B) written notice of any change in its
25 designation of its primary State; and

1 “(C) written notice from the issuer of the
2 issuer’s compliance with all the laws of the pri-
3 mary State; and

4 “(2) to the insurance commissioner of each sec-
5 ondary State in which it offers individual health in-
6 surance coverage, a copy of the issuer’s quarterly fi-
7 nancial statement submitted to the primary State,
8 which statement shall be certified by an independent
9 public accountant and contain a statement of opin-
10 ion on loss and loss adjustment expense reserves
11 made by—

12 “(A) a member of the American Academy
13 of Actuaries; or

14 “(B) a qualified loss reserve specialist.

15 “(h) POWER OF COURTS TO ENJOIN CONDUCT.—
16 Nothing in this section shall be construed to affect the
17 authority of any Federal or State court to enjoin—

18 “(1) the solicitation or sale of individual health
19 insurance coverage by a health insurance issuer to
20 any person or group who is not eligible for such in-
21 surance; or

22 “(2) the solicitation or sale of individual health
23 insurance coverage that violates the requirements of
24 the law of a secondary State which are described in

1 subparagraphs (A) through (H) of section
2 2796(b)(1).

3 “(i) POWER OF SECONDARY STATES TO TAKE AD-
4 MINISTRATIVE ACTION.—Nothing in this section shall be
5 construed to affect the authority of any State to enjoin
6 conduct in violation of that State’s laws described in sec-
7 tion 2796(b)(1).

8 “(j) STATE POWERS TO ENFORCE STATE LAWS.—

9 “(1) IN GENERAL.—Subject to the provisions of
10 subsection (b)(1)(G) (relating to injunctions) and
11 paragraph (2), nothing in this section shall be con-
12 strued to affect the authority of any State to make
13 use of any of its powers to enforce the laws of such
14 State with respect to which a health insurance issuer
15 is not exempt under subsection (b).

16 “(2) COURTS OF COMPETENT JURISDICTION.—

17 If a State seeks an injunction regarding the conduct
18 described in paragraphs (1) and (2) of subsection
19 (h), such injunction must be obtained from a Fed-
20 eral or State court of competent jurisdiction.

21 “(k) STATES’ AUTHORITY TO SUE.—Nothing in this
22 section shall affect the authority of any State to bring ac-
23 tion in any Federal or State court.

24 “(l) GENERALLY APPLICABLE LAWS.—Nothing in
25 this section shall be construed to affect the applicability

1 of State laws generally applicable to persons or corpora-
2 tions.

3 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO
4 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a
5 health insurance issuer is offering coverage in a primary
6 State that does not accommodate residents of secondary
7 States or does not provide a working mechanism for resi-
8 dents of a secondary State, and the issuer is offering cov-
9 erage under this part in such secondary State which has
10 not adopted a qualified high-risk pool as its acceptable al-
11 ternative mechanism (as defined in section 2744(c)(2)),
12 the issuer shall, with respect to any individual health in-
13 surance coverage offered in a secondary State under this
14 part, comply with the guaranteed availability requirements
15 for eligible individuals in section 2741.

16 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**
17 **BEFORE ISSUER MAY SELL INTO SECONDARY**
18 **STATES.**

19 “A health insurance issuer may not offer, sell, or
20 issue individual health insurance coverage in a secondary
21 State if the State insurance commissioner does not use
22 a risk-based capital formula for the determination of cap-
23 ital and surplus requirements for all health insurance
24 issuers.

1 **“SEC. 2798. LIMITATION ON INDIVIDUAL PURCHASE IN SEC-**
2 **ONDARY STATE.**

3 “Effective beginning two years after the date of en-
4 actment of this part, an individual in a State may not
5 buy individual health insurance coverage in a secondary
6 State if the premium for individual health insurance in
7 the primary State (with respect to the individual) exceeds
8 the national average premium by 10 percent or more.

9 **“SEC. 2799. INDEPENDENT EXTERNAL APPEALS PROCE-**
10 **DURES.**

11 “(a) **RIGHT TO EXTERNAL APPEAL.**—A health insur-
12 ance issuer may not offer, sell, or issue individual health
13 insurance coverage in a secondary State under the provi-
14 sions of this title unless—

15 “(1) both the secondary State and the primary
16 State have legislation or regulations in place estab-
17 lishing an independent review process for individuals
18 who are covered by individual health insurance cov-
19 erage, or

20 “(2) in any case in which the requirements of
21 subparagraph (A) are not met with respect to the ei-
22 ther of such States, the issuer provides an inde-
23 pendent review mechanism substantially identical (as
24 determined by the applicable State authority of such
25 State) to that prescribed in the ‘Health Carrier Ex-
26 ternal Review Model Act’ of the National Association

1 of Insurance Commissioners for all individuals who
2 purchase insurance coverage under the terms of this
3 part, except that, under such mechanism, the review
4 is conducted by an independent medical reviewer, or
5 a panel of such reviewers, with respect to whom the
6 requirements of subsection (b) are met.

7 “(b) QUALIFICATIONS OF INDEPENDENT MEDICAL
8 REVIEWERS.—In the case of any independent review
9 mechanism referred to in subsection (a)(2)—

10 “(1) IN GENERAL.—In referring a denial of a
11 claim to an independent medical reviewer, or to any
12 panel of such reviewers, to conduct independent
13 medical review, the issuer shall ensure that—

14 “(A) each independent medical reviewer
15 meets the qualifications described in paragraphs
16 (2) and (3);

17 “(B) with respect to each review, each re-
18 viewer meets the requirements of paragraph (4)
19 and the reviewer, or at least 1 reviewer on the
20 panel, meets the requirements described in
21 paragraph (5); and

22 “(C) compensation provided by the issuer
23 to each reviewer is consistent with paragraph
24 (6).

1 “(2) LICENSURE AND EXPERTISE.—Each inde-
2 pendent medical reviewer shall be a physician
3 (allopathic or osteopathic) or health care profes-
4 sional who—

5 “(A) is appropriately credentialed or li-
6 censed in one or more States to deliver health
7 care services; and

8 “(B) typically treats the condition, makes
9 the diagnosis, or provides the type of treatment
10 under review.

11 “(3) INDEPENDENCE.—

12 “(A) IN GENERAL.—Subject to subpara-
13 graph (B), each independent medical reviewer
14 in a case shall—

15 “(i) not be a related party (as defined
16 in paragraph (7));

17 “(ii) not have a material familial, fi-
18 nancial, or professional relationship with
19 such a party; and

20 “(iii) not otherwise have a conflict of
21 interest with such a party (as determined
22 under regulations).

23 “(B) EXCEPTION.—Nothing in subpara-
24 graph (A) shall be construed to—

1 “(i) prohibit an individual, solely on
2 the basis of affiliation with the issuer,
3 from serving as an independent medical re-
4 viewer if—

5 “(I) a non-affiliated individual is
6 not reasonably available;

7 “(II) the affiliated individual is
8 not involved in the provision of items
9 or services in the case under review;

10 “(III) the fact of such an affili-
11 ation is disclosed to the issuer and the
12 enrollee (or authorized representative)
13 and neither party objects; and

14 “(IV) the affiliated individual is
15 not an employee of the issuer and
16 does not provide services exclusively or
17 primarily to or on behalf of the issuer;

18 “(ii) prohibit an individual who has
19 staff privileges at the institution where the
20 treatment involved takes place from serv-
21 ing as an independent medical reviewer
22 merely on the basis of such affiliation if
23 the affiliation is disclosed to the issuer and
24 the enrollee (or authorized representative),
25 and neither party objects; or

1 “(iii) prohibit receipt of compensation
2 by an independent medical reviewer from
3 an entity if the compensation is provided
4 consistent with paragraph (6).

5 “(4) PRACTICING HEALTH CARE PROFESSIONAL
6 IN SAME FIELD.—

7 “(A) IN GENERAL.—In a case involving
8 treatment, or the provision of items or serv-
9 ices—

10 “(i) by a physician, a reviewer shall be
11 a practicing physician (allopathic or osteo-
12 pathic) of the same or similar specialty, as
13 a physician who, acting within the appro-
14 priate scope of practice within the State in
15 which the service is provided or rendered,
16 typically treats the condition, makes the
17 diagnosis, or provides the type of treat-
18 ment under review; or

19 “(ii) by a non-physician health care
20 professional, the reviewer, or at least 1
21 member of the review panel, shall be a
22 practicing non-physician health care pro-
23 fessional of the same or similar specialty
24 as the non-physician health care profes-
25 sional who, acting within the appropriate

1 scope of practice within the State in which
2 the service is provided or rendered, typi-
3 cally treats the condition, makes the diag-
4 nosis, or provides the type of treatment
5 under review.

6 “(B) PRACTICING DEFINED.—For pur-
7 poses of this paragraph, the term ‘practicing’
8 means, with respect to an individual who is a
9 physician or other health care professional, that
10 the individual provides health care services to
11 individual patients on average at least 2 days
12 per week.

13 “(5) PEDIATRIC EXPERTISE.—In the case of an
14 external review relating to a child, a reviewer shall
15 have expertise under paragraph (2) in pediatrics.

16 “(6) LIMITATIONS ON REVIEWER COMPENSA-
17 TION.—Compensation provided by the issuer to an
18 independent medical reviewer in connection with a
19 review under this section shall—

20 “(A) not exceed a reasonable level; and

21 “(B) not be contingent on the decision ren-
22 dered by the reviewer.

23 “(7) RELATED PARTY DEFINED.—For purposes
24 of this section, the term ‘related party’ means, with

1 respect to a denial of a claim under a coverage relat-
2 ing to an enrollee, any of the following:

3 “(A) The issuer involved, or any fiduciary,
4 officer, director, or employee of the issuer.

5 “(B) The enrollee (or authorized represent-
6 ative).

7 “(C) The health care professional that pro-
8 vides the items or services involved in the de-
9 nial.

10 “(D) The institution at which the items or
11 services (or treatment) involved in the denial
12 are provided.

13 “(E) The manufacturer of any drug or
14 other item that is included in the items or serv-
15 ices involved in the denial.

16 “(F) Any other party determined under
17 any regulations to have a substantial interest in
18 the denial involved.

19 “(8) DEFINITIONS.—For purposes of this sub-
20 section:

21 “(A) ENROLLEE.—The term ‘enrollee’
22 means, with respect to health insurance cov-
23 erage offered by a health insurance issuer, an
24 individual enrolled with the issuer to receive
25 such coverage.

1 “(B) HEALTH CARE PROFESSIONAL.—The
2 term ‘health care professional’ means an indi-
3 vidual who is licensed, accredited, or certified
4 under State law to provide specified health care
5 services and who is operating within the scope
6 of such licensure, accreditation, or certification.

7 **“SEC. 2800. ENFORCEMENT.**

8 “(a) IN GENERAL.—Subject to subsection (b), with
9 respect to specific individual health insurance coverage the
10 primary State for such coverage has sole jurisdiction to
11 enforce the primary State’s covered laws in the primary
12 State and any secondary State.

13 “(b) SECONDARY STATE’S AUTHORITY.—Nothing in
14 subsection (a) shall be construed to affect the authority
15 of a secondary State to enforce its laws as set forth in
16 the exception specified in section 2796(b)(1).

17 “(c) COURT INTERPRETATION.—In reviewing action
18 initiated by the applicable secondary State authority, the
19 court of competent jurisdiction shall apply the covered
20 laws of the primary State.

21 “(d) NOTICE OF COMPLIANCE FAILURE.—In the case
22 of individual health insurance coverage offered in a sec-
23 ondary State that fails to comply with the covered laws
24 of the primary State, the applicable State authority of the

1 secondary State may notify the applicable State authority
2 of the primary State.”.

3 (b) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall apply to individual health insurance
5 coverage offered, issued, or sold after the date that is one
6 year after the date of the enactment of this Act.

7 (c) GAO ONGOING STUDY AND REPORTS.—

8 (1) STUDY.—The Comptroller General of the
9 United States shall conduct an ongoing study con-
10 cerning the effect of the amendment made by sub-
11 section (a) on—

12 (A) the number of uninsured and under-in-
13 sured;

14 (B) the availability and cost of health in-
15 surance policies for individuals with pre-existing
16 medical conditions;

17 (C) the availability and cost of health in-
18 surance policies generally;

19 (D) the elimination or reduction of dif-
20 ferent types of benefits under health insurance
21 policies offered in different States; and

22 (E) cases of fraud or abuse relating to
23 health insurance coverage offered under such
24 amendment and the resolution of such cases.

1 (2) ANNUAL REPORTS.—The Comptroller Gen-
 2 eral shall submit to Congress an annual report, after
 3 the end of each of the 5 years following the effective
 4 date of the amendment made by subsection (a), on
 5 the ongoing study conducted under paragraph (1).

6 (d) SEVERABILITY.—If any provision of the section
 7 or the application of such provision to any person or cir-
 8 cumstance is held to be unconstitutional, the remainder
 9 of this section and the application of the provisions of such
 10 to any other person or circumstance shall not be affected.

11 **TITLE IV—SAFETY NET** 12 **REFORMS**

13 **SEC. 401. REQUIRING OUTREACH AND COVERAGE BEFORE** 14 **EXPANSION OF ELIGIBILITY.**

15 (a) STATE CHILD HEALTH PLAN REQUIRED TO
 16 SPECIFY HOW IT WILL ACHIEVE COVERAGE FOR 90 PER-
 17 CENT OF TARGETED LOW-INCOME CHILDREN.—

18 (1) IN GENERAL.—Section 2102(a) of the So-
 19 cial Security Act (42 U.S.C. 1397bb(a)) is amend-
 20 ed—

21 (A) in paragraph (6), by striking “and” at
 22 the end;

23 (B) in paragraph (7), by striking the pe-
 24 riod at the end and inserting “; and”; and

1 (C) by adding at the end the following new
2 paragraph:

3 “(8) how the eligibility and benefits provided
4 for under the plan for each fiscal year (beginning
5 with fiscal year 2015) will allow for the State’s an-
6 nual funding allotment to cover at least 90 percent
7 of the eligible targeted low-income children in the
8 State.”.

9 (2) EFFECTIVE DATE.—The amendments made
10 by paragraph (1) shall apply to State child health
11 plans for fiscal years beginning with fiscal year
12 2015.

13 (b) LIMITATION ON PROGRAM EXPANSIONS UNTIL
14 LOWEST INCOME ELIGIBLE INDIVIDUALS ENROLLED.—
15 Section 2105(c) of the Social Security Act (42 U.S.C.
16 1397dd(c)) is amended by adding at the end the following
17 new paragraph:

18 “(12) LIMITATION ON INCREASED COVERAGE
19 OF HIGHER INCOME CHILDREN.—

20 “(A) IN GENERAL.—For child health as-
21 sistance furnished in a fiscal year beginning
22 with fiscal year 2015:

23 “(i) NO PAYMENT FOR CHILDREN
24 WITH FAMILY INCOME ABOVE 300 PERCENT
25 OF POVERTY LINE.—Payment shall not be

1 made under this section for child health
2 assistance for a targeted low-income child
3 in a family the income of which exceeds
4 300 percent of the poverty line applicable
5 to a family of the size involved.

6 “(ii) SPECIAL RULES FOR PAYMENT
7 FOR CHILDREN WITH FAMILY INCOME
8 ABOVE 200 PERCENT OF POVERTY LINE.—

9 In the case of child health assistance for a
10 targeted low-income child in a family the
11 income of which exceeds 200 percent (but
12 does not exceed 300 percent) of the pov-
13 erty line applicable to a family of the size
14 involved no payment shall be made under
15 this section for such assistance unless the
16 State demonstrates to the satisfaction of
17 the Secretary that—

18 “(I) the State has met the 90
19 percent retrospective coverage test
20 specified in subparagraph (B)(i) for
21 the previous fiscal year; and

22 “(II) the State will meet the 90
23 percent prospective coverage test spec-
24 ified in subparagraph (B)(ii) for the
25 fiscal year.

1 “(B) 90 PERCENT COVERAGE TESTS.—

2 “(i) RETROSPECTIVE TEST.—The 90
3 percent retrospective coverage test speci-
4 fied in this clause is, for a State for a fis-
5 cal year, that on average during the fiscal
6 year, the State has enrolled under this title
7 or title XIX at least 90 percent of the indi-
8 viduals residing in the State who—

9 “(I) are children under 19 years
10 of age (or are pregnant women) and
11 are eligible for medical assistance
12 under title XIX; or

13 “(II) are targeted low-income
14 children whose family income does not
15 exceed 200 percent of the poverty line
16 and who are eligible for child health
17 assistance under this title.

18 “(ii) PROSPECTIVE TEST.—The 90
19 percent prospective test specified in this
20 clause is, for a State for a fiscal year, that
21 on average during the fiscal year, the State
22 will enroll under this title or title XIX at
23 least 90 percent of the individuals residing
24 in the State who—

1 “(I) are children under 19 years
2 of age (or are pregnant women) and
3 are eligible for medical assistance
4 under title XIX; or

5 “(II) are targeted low-income
6 children whose family income does not
7 exceed such percent of the poverty
8 line (in excess of 200 percent) as the
9 State elects consistent with this para-
10 graph and who are eligible for child
11 health assistance under this title.

12 “(C) GRANDFATHER.—Clauses (i) and (ii)
13 of subparagraph (A) shall not apply to the pro-
14 vision of child health assistance—

15 “(i) to a targeted low-income child
16 who is enrolled for child health assistance
17 under this title as of September 30, 2012;

18 “(ii) to a pregnant woman who is en-
19 rolled for assistance under this title as of
20 September 30, 2013, through the comple-
21 tion of the post-partum period following
22 completion of her pregnancy; and

23 “(iii) for items and services furnished
24 before October 1, 2014, to an individual
25 who is not a targeted low-income child and

1 who is enrolled for assistance under this
2 title as of September 30, 2013.

3 “(D) TREATMENT OF PREGNANT
4 WOMEN.—In this paragraph and sections
5 2102(a)(8) and 2104(a)(2), the term ‘targeted
6 low-income child’ includes an individual under
7 age 19, including the period from conception to
8 birth, who is eligible for child health assistance
9 under this title by virtue of the definition of the
10 term ‘child’ under section 457.10 of title 42,
11 Code of Federal Regulations.”.

12 (c) STANDARDIZATION OF INCOME DETERMINA-
13 TIONS.—

14 (1) IN GENERAL.—Section 2110 of the Social
15 Security Act (42 U.S.C. 1397jj) is amended by add-
16 ing at the end the following new subsection:

17 “(d) STANDARDIZATION OF INCOME DETERMINA-
18 TIONS.—In determining family income under this title (in-
19 cluding in the case of a State child health plan that pro-
20 vides health benefits coverage in the manner described in
21 section 2101(a)(2)), a State shall base such determination
22 on gross income (including amounts that would be in-
23 cluded in gross income if they were not exempt from in-
24 come taxation) and may only take into consideration such
25 income disregards as the Secretary shall develop.”.

1 (2) EFFECTIVE DATE.—(A) Subject to subpara-
2 graph (B), the amendment made by paragraph (1)
3 shall apply to determinations (and redeterminations)
4 of income made on or after April 1, 2012.

5 (B) In the case of a State child health plan
6 under title XXI of the Social Security Act which the
7 Secretary of Health and Human Services determines
8 requires State legislation (other than legislation ap-
9 propriating funds) in order for the plan to meet the
10 additional requirement imposed by the amendment
11 made by paragraph (1), the State child health plan
12 shall not be regarded as failing to comply with the
13 requirements of such title solely on the basis of its
14 failure to meet this additional requirement before
15 the first day of the first calendar quarter beginning
16 after the close of the first regular session of the
17 State legislature that begins after the date of the en-
18 actment of this Act. For purposes of the previous
19 sentence, in the case of a State that has a 2-year
20 legislative session, each year of such session shall be
21 deemed to be a separate regular session of the State
22 legislature.

1 **SEC. 402. EASING ADMINISTRATIVE BARRIERS TO STATE**
2 **COOPERATION WITH EMPLOYER-SPONSORED**
3 **INSURANCE COVERAGE.**

4 (a) **REQUIRING SOME COVERAGE FOR EMPLOYER-**
5 **SPONSORED INSURANCE UNDER CHIP.**—Section 2102(a)
6 of the Social Security Act (42 U.S.C. 1397b(a)), as
7 amended by section 401(a), is amended—

8 (1) in paragraph (7), by striking “and” at the
9 end;

10 (2) in paragraph (8), by striking the period at
11 the end and inserting “; and”; and

12 (3) by adding at the end the following new
13 paragraph:

14 “(9) effective for plan years beginning on or
15 after October 1, 2014, how the plan will provide for
16 child health assistance with respect to targeted low-
17 income children covered under a group health
18 plan.”.

19 (b) **FEDERAL FINANCIAL PARTICIPATION FOR EM-**
20 **PLOYER-SPONSORED INSURANCE.**—Section 2105 of the
21 Social Security Act (42 U.S.C. 1397d) is amended—

22 (1) in subsection (a)(1)(C), by inserting before
23 the semicolon at the end the following: “and, subject
24 to paragraph (3)(C), in the form of payment of the
25 premiums for coverage under a group health plan
26 that includes coverage of targeted low-income chil-

1 dren and benefits supplemental to such coverage”;
2 and

3 (2) by amending paragraph (3) of subsection
4 (c) to read as follows:

5 “(3) PURCHASE OF EMPLOYER-SPONSORED IN-
6 SURANCE.—

7 “(A) IN GENERAL.—Payment may be
8 made to a State under subsection (a)(1)(C),
9 subject to the provisions of this paragraph, for
10 the purchase of family coverage under a group
11 health plan that includes coverage of targeted
12 low-income children unless such coverage would
13 otherwise substitute for coverage that would be
14 provided to such children but for the purchase
15 of family coverage.

16 “(B) WAIVER OF CERTAIN PROVISIONS.—
17 With respect to coverage described in subpara-
18 graph (A)—

19 “(i) notwithstanding section 2102, no
20 minimum benefits requirement (other than
21 those otherwise applicable with respect to
22 services referred to in section 2102(a)(7))
23 under this title shall apply; and

1 “(ii) no limitation on beneficiary cost-
2 sharing otherwise applicable under this
3 title or title XIX shall apply.

4 “(C) REQUIRED PROVISION OF SUPPLE-
5 MENTAL BENEFITS.—If the coverage described
6 in subparagraph (A) does not provide coverage
7 for the services referred to in section
8 2102(a)(7), the State child health plan shall
9 provide coverage of such services as supple-
10 mental benefits.

11 “(D) LIMITATION ON FFP.—The amount
12 of the payment under paragraph (1)(C) for cov-
13 erage described in subparagraph (A) (and sup-
14 plemental benefits under subparagraph (C) for
15 individuals so covered) during a fiscal year may
16 not exceed the product of—

17 “(i) the national per capita expendi-
18 ture under this title (taking into account
19 both Federal and State expenditures) for
20 the previous fiscal year (as determined by
21 the Secretary using the best available
22 data);

23 “(ii) the enhanced FMAP for the
24 State and fiscal year involved; and

1 “(iii) the number of targeted low-in-
2 come children for whom such coverage is
3 provided.

4 “(E) VOLUNTARY ENROLLMENT.—A State
5 child health plan—

6 “(i) may not require a targeted low-
7 income child to enroll in coverage described
8 in subparagraph (A) in order to obtain
9 child health assistance under this title;

10 “(ii) before providing such child
11 health assistance for such coverage of a
12 child, shall make available (which may be
13 through an Internet Web site or other
14 means including the State transparency
15 plan portal established under section 901
16 of the Empowering Patients First Act of
17 2013) to the parent or guardian of the
18 child information on the coverage available
19 under this title, including benefits and
20 cost-sharing; and

21 “(iii) shall provide at least one oppor-
22 tunity per fiscal year for beneficiaries to
23 switch coverage under this title from cov-
24 erage described in subparagraph (A) to the

1 coverage that is otherwise made available
2 under this title.

3 “(F) INFORMATION ON COVERAGE OP-
4 TIONS.—A State child health plan shall—

5 “(i) describe how the State will notify
6 potential beneficiaries of coverage de-
7 scribed in subparagraph (A);

8 “(ii) provide such notification in writ-
9 ing at least during the initial application
10 for enrollment under this title and during
11 redeterminations of eligibility if the indi-
12 vidual was enrolled before October 1, 2014;
13 and

14 “(iii) post a description of these cov-
15 erage options on any official Web site that
16 may be established by the State in connec-
17 tion with the plan, including the State
18 transparency plan portal established under
19 section 901 of the Empowering Patients
20 First Act of 2013.

21 “(G) SEMIANNUAL VERIFICATION OF COV-
22 ERAGE.—If coverage described in subparagraph
23 (A) is provided under a group health plan with
24 respect to a targeted low-income child, the
25 State child health plan shall provide for the col-

1 lection, at least once every six months, of proof
2 from the plan that the child is enrolled in such
3 coverage.

4 “(H) RULE OF CONSTRUCTION.—Nothing
5 in this section is to be construed to prohibit a
6 State from—

7 “(i) offering wrap around benefits in
8 order for a group health plan to meet any
9 State-established minimum benefit require-
10 ments;

11 “(ii) establishing a cost-effectiveness
12 test to qualify for coverage under such a
13 plan;

14 “(iii) establishing limits on beneficiary
15 cost-sharing under such a plan;

16 “(iv) paying all or part of a bene-
17 ficiary’s cost-sharing requirements under
18 such a plan;

19 “(v) paying less than the full cost of
20 the employee’s share of the premium under
21 such a plan, including prorating the cost of
22 the premium to pay for only what the
23 State determines is the portion of the pre-
24 mium that covers targeted low-income chil-
25 dren;

1 “(vi) using State funds to pay for
2 benefits above the Federal upper limit es-
3 tablished under subparagraph (C);

4 “(vii) allowing beneficiaries enrolled in
5 group health plans from changing plans to
6 another coverage option available under
7 this title at any time; or

8 “(viii) providing any guidance or in-
9 formation it deems appropriate in order to
10 help beneficiaries make an informed deci-
11 sion regarding the option to enroll in cov-
12 erage described in subparagraph (A).

13 “(I) GROUP HEALTH PLAN DEFINED.—In
14 this paragraph, the term ‘group health plan’
15 has the meaning given such term in section
16 2791(a)(1) of the Public Health Service Act (42
17 U.S.C. 300gg-91(a)(1)).”.

18 (c) APPLICATION UNDER MEDICAID.—The Secretary
19 of Health and Human Services shall provide for the appli-
20 cation of the amendments made by subsections (a) and
21 (b) under the Medicaid program under title XIX of the
22 Social Security Act in the same manner as such amend-
23 ments apply to SCHIP under title XXI of such Act.

1 **SEC. 403. IMPROVING BENEFICIARY CHOICE IN SCHIP.**

2 (a) **REQUIRING OFFERING OF ALTERNATIVE COV-**
3 **ERAGE OPTIONS.**—Section 2102 of the Social Security Act
4 (42 U.S.C. 1397b), as amended by sections 401(a) and
5 402(a), is amended—

6 (1) in subsection (a)—

7 (A) in paragraph (8), by striking “and” at
8 the end;

9 (B) in paragraph (9), by striking the pe-
10 riod at the end and inserting “; and”; and

11 (C) by adding at the end the following new
12 paragraph:

13 “(10) effective for plan years beginning on or
14 after October 1, 2014, how the plan will provide for
15 child health assistance with respect to targeted low-
16 income children through alternative coverage options
17 in accordance with subsection (e).”; and

18 (2) by adding at the end the following new sub-
19 section:

20 “(d) **ALTERNATIVE COVERAGE OPTIONS.**—

21 “(1) **IN GENERAL.**—Effective October 1, 2014,
22 a State child health plan shall provide for the offer-
23 ing of any qualified alternative coverage that a
24 qualified entity seeks to offer to targeted low-income
25 children through the plan in the State.

1 “(2) APPLICATION OF UNIFORM FINANCIAL
2 LIMITATION FOR ALL ALTERNATIVE COVERAGE OP-
3 TIONS.—With respect to all qualified alternative cov-
4 erage offered in a State, the State child health plan
5 shall establish a uniform dollar limitation on the per
6 capita monthly amount that will be paid by the
7 State to the qualified entity with respect to such
8 coverage provided to a targeted low-income child.
9 Such limitation may not be less than 90 percent of
10 the per capita monthly payment made for coverage
11 offered under the State child health plan that is not
12 in the form of an alternative coverage option. Noth-
13 ing in this paragraph shall be construed—

14 “(A) as requiring a State to provide for
15 the full payment of premiums for qualified al-
16 ternative coverage;

17 “(B) as preventing a State from charging
18 additional premiums to cover the difference be-
19 tween the cost of qualified alternative coverage
20 and the amount of such payment limitation; or

21 “(C) as preventing a State from using its
22 own funds to provide a dollar limitation that ex-
23 ceeds the Federal financial participation as lim-
24 ited under section 2105(c)(10).

25 “(3) TREATMENT OF LOW COST COVERAGE.—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B), if the uniform dollar limita-
3 tion under paragraph (2) exceeds the premium
4 for qualified alternative coverage for an en-
5 rollee, then such excess shall be refunded to the
6 Federal and State governments in the same
7 proportion as is otherwise applicable to recov-
8 ered funds under this title.

9 “(B) EXCEPTION FOR HIGH-DEDUCTIBLE
10 HEALTH PLANS.—In the case of coverage under
11 a high-deductible health plan, the excess de-
12 scribed in subparagraph (A) shall be deposited
13 into a health savings account established with
14 respect to such plan.

15 “(4) EXEMPTION.—A State is not subject to
16 the requirement of paragraph (1) if the State child
17 health plan provides, as of the date of the enactment
18 of this subsection, for a cash out or health savings
19 account type option for those enrolled under the
20 plan.

21 “(5) QUALIFIED ALTERNATIVE COVERAGE DE-
22 FINED.—In this section, the term ‘qualified alter-
23 native coverage’ means health insurance coverage
24 that—

1 “(A) meets the coverage requirements of
2 section 2103 (other than cost-sharing require-
3 ments of such section); and

4 “(B) is offered by a qualified insurer, and
5 not directly by the State.

6 “(6) QUALIFIED INSURER DEFINED.—In this
7 section, the term ‘qualified insurer’ means, with re-
8 spect to a State, an entity that is licensed to offer
9 health insurance coverage in the State.”.

10 (b) FEDERAL FINANCIAL PARTICIPATION FOR
11 QUALIFIED ALTERNATIVE COVERAGE.—Section 2105 of
12 the Social Security Act (42 U.S.C. 1397d) is amended—

13 (1) in subsection (a)(1)(C), as amended by sec-
14 tion 402(b), by inserting before the semicolon at the
15 end the following: “and, subject to paragraph
16 (13)(C), in the form of payment of the premiums for
17 coverage for qualified alternative coverage”; and

18 (2) in subsection (c), as amended by section
19 401(b) by adding at the end the following new para-
20 graph:

21 “(13) PURCHASE OF QUALIFIED ALTERNATIVE
22 COVERAGE.—

23 “(A) IN GENERAL.—Payment may be
24 made to a State under subsection (a)(1)(C),

1 subject to the provisions of this paragraph, for
2 the purchase of qualified alternative coverage.

3 “(B) WAIVER OF CERTAIN PROVISIONS.—
4 With respect to coverage described in subpara-
5 graph (A), no limitation on beneficiary cost-
6 sharing otherwise applicable under this title or
7 title XIX shall apply.

8 “(C) LIMITATION ON FFP.—The amount of
9 the payment under paragraph (1)(C) for cov-
10 erage described in subparagraph (A) during a
11 fiscal year in the aggregate for all such cov-
12 erage in the State may not exceed the product
13 of—

14 “(i) the national per capita expendi-
15 ture under this title (taking into account
16 both Federal and State expenditures) for
17 the previous fiscal year (as determined by
18 the Secretary using the best available
19 data);

20 “(ii) the enhanced FMAP for the
21 State and fiscal year involved; and

22 “(iii) the number of targeted low-in-
23 come children for whom such coverage is
24 provided.

1 “(D) VOLUNTARY ENROLLMENT.—A State
2 child health plan—

3 “(i) may not require a targeted low-
4 income child to enroll in coverage described
5 in subparagraph (A) in order to obtain
6 child health assistance under this title;

7 “(ii) before providing such child
8 health assistance for such coverage of a
9 child, shall make available (which may be
10 through an Internet Web site or other
11 means) to the parent or guardian of the
12 child information on the coverage available
13 under this title, including benefits and
14 cost-sharing; and

15 “(iii) shall provide at least one oppor-
16 tunity per fiscal year for beneficiaries to
17 switch coverage under this title from cov-
18 erage described in subparagraph (A) to the
19 coverage that is otherwise made available
20 under this title.

21 “(E) INFORMATION ON COVERAGE OP-
22 TIONS.—A State child health plan shall—

23 “(i) describe how the State will notify
24 potential beneficiaries of coverage de-
25 scribed in subparagraph (A);

1 “(ii) provide such notification in writ-
2 ing at least during the initial application
3 for enrollment under this title and during
4 redeterminations of eligibility if the indi-
5 vidual was enrolled before October 1, 2014;
6 and

7 “(iii) post a description of these cov-
8 erage options on any official Web site that
9 may be established by the State in connec-
10 tion with the plan.

11 “(F) RULE OF CONSTRUCTION.—Nothing
12 in this section is to be construed to prohibit a
13 State from—

14 “(i) establishing limits on beneficiary
15 cost-sharing under such alternative cov-
16 erage;

17 “(ii) paying all or part of a bene-
18 ficiary’s cost-sharing requirements under
19 such coverage;

20 “(iii) paying less than the full cost of
21 a child’s share of the premium under such
22 coverage, insofar as the premium for such
23 coverage exceeds the limitation established
24 by the State under subparagraph (C);

1 “(iv) using State funds to pay for
2 benefits above the Federal upper limit es-
3 tablished under subparagraph (C); or

4 “(v) providing any guidance or infor-
5 mation it deems appropriate in order to
6 help beneficiaries make an informed deci-
7 sion regarding the option to enroll in cov-
8 erage described in subparagraph (A).”.

9 (c) APPLICATION UNDER MEDICAID.—The Secretary
10 of Health and Human Services shall provide for the appli-
11 cation of the amendments made by subsections (a) and
12 (b) under the Medicaid program under title XIX of the
13 Social Security Act in the same manner as such amend-
14 ments apply to SCHIP under title XXI of such Act.

15 **TITLE V—LAWSUIT ABUSE**
16 **REFORMS**

17 **SEC. 501. CHANGE IN BURDEN OF PROOF BASED ON COM-**
18 **PLIANCE WITH BEST PRACTICE GUIDELINES.**

19 (a) SELECTION AND ISSUANCE OF BEST PRACTICES
20 GUIDELINES.—

21 (1) IN GENERAL.—The Secretary of Health and
22 Human Services (in this section referred to as the
23 “Secretary”) shall provide for the selection and
24 issuance of best practice guidelines for treatment of
25 medical conditions (each in this subsection referred

1 to as a “guideline”) in accordance with paragraphs
2 (2) and (3).

3 (2) DEVELOPMENT PROCESS.—Not later than
4 90 days after the date of enactment of this title, the
5 Secretary shall enter into a contract with a qualified
6 physician consensus-building organization (such as
7 the Physician Consortium for Performance Improve-
8 ment), in concert and agreement with physician spe-
9 cialty organizations, to develop guidelines. The con-
10 tract shall require that the organization submit
11 guidelines to the agency not later than 18 months
12 after the date of the enactment of this title.

13 (3) ISSUANCE.—

14 (A) IN GENERAL.—Not later than 2 years
15 after the date of the enactment of this title, the
16 Secretary shall, after notice and opportunity for
17 public comment, make a rule that provides for
18 the issuance of the guidelines submitted under
19 paragraph (2).

20 (B) LIMITATION.—The Secretary may not
21 make a rule that includes guidelines other than
22 those submitted under paragraph (2).

23 (C) DISSEMINATION.—The Secretary shall
24 post such guidelines on the public Internet Web

1 page of the Department of Health and Human
2 Services.

3 (4) MAINTENANCE.—Not later than 4 years
4 after the date of enactment of this title, and every
5 2 years thereafter, the Secretary shall review the
6 guidelines and shall, as necessary, enter into con-
7 tracts similar to the contract described in paragraph
8 (2), and issue guidelines in a manner similar to the
9 issuance of guidelines under paragraph (3).

10 (b) USE.—

11 (1) USE BY DEFENDANT TO CHANGE THE BUR-
12 DEN OF PROOF.—If a defendant in a health care
13 lawsuit relating to treatment of an individual estab-
14 lishes by a preponderance of the evidence that the
15 treatment was provided in a manner consistent with
16 an applicable guideline issued under subsection (a),
17 the defendant may not be held liable unless the
18 plaintiff establishes the liability of the defendant by
19 clear and convincing evidence.

20 (2) LIMITATION ON INTRODUCTION AS EVI-
21 DENCE AGAINST A DEFENDANT.—Guidelines issued
22 under subsection (a) may not be introduced as evi-
23 dence of negligence or deviation in the standard of
24 care in any health care lawsuit unless they have pre-
25 viously been introduced by the defendant.

1 (3) NO PRESUMPTION OF NEGLIGENCE AGAINST
2 A DEFENDANT.—There shall be no presumption of
3 negligence with respect to treatment if a health care
4 provider provides the treatment in a manner incon-
5 sistent with such guidelines.

6 (c) CONSTRUCTION.—Nothing in this section shall be
7 construed as preventing a State from—

8 (1) replacing their current medical malpractice
9 rules with rules that rely, as a defense, upon a
10 health care provider’s compliance with a guideline
11 issued under subsection (a); or

12 (2) applying additional guidelines or limitations
13 on liability that are in addition to, but not in lieu
14 of, the guidelines issued under subsection (a).

15 **SEC. 502. STATE GRANTS TO CREATE ADMINISTRATIVE**
16 **HEALTH CARE TRIBUNALS.**

17 Part P of title III of the Public Health Service Act
18 (42 U.S.C. 280g et seq.) is amended by adding at the end
19 the following:

20 **“SEC. 399T. STATE GRANTS TO CREATE ADMINISTRATIVE**
21 **HEALTH CARE TRIBUNALS.**

22 “(a) IN GENERAL.—The Secretary may award grants
23 to States for the development, implementation, and eval-
24 uation of administrative health care tribunals that comply

1 with this section, for the resolution of disputes concerning
2 injuries allegedly caused by health care providers.

3 “(b) CONDITIONS FOR DEMONSTRATION GRANTS.—

4 To be eligible to receive a grant under this section, a State
5 shall submit to the Secretary an application at such time,
6 in such manner, and containing such information as may
7 be required by the Secretary. A grant shall be awarded
8 under this section on such terms and conditions as the
9 Secretary determines appropriate.

10 “(c) REPRESENTATION BY COUNSEL.—A State that

11 receives a grant under this section may not preclude any
12 party to a dispute before an administrative health care tri-
13 bunal operated under such grant from obtaining legal rep-
14 resentation during any review by the expert panel under
15 subsection (d), the administrative health care tribunal
16 under subsection (e), or a State court under subsection
17 (f).

18 “(d) EXPERT PANEL REVIEW AND EARLY OFFER

19 GUIDELINES.—

20 “(1) IN GENERAL.—Prior to the submission of
21 any dispute concerning injuries allegedly caused by
22 health care providers to an administrative health
23 care tribunal under this section, such allegations
24 shall first be reviewed by an expert panel.

25 “(2) COMPOSITION.—

1 “(A) IN GENERAL.—The members of each
2 expert panel under this subsection shall be ap-
3 pointed by the head of the State agency respon-
4 sible for health. Each expert panel shall be
5 composed of no fewer than 3 members and not
6 more than 7 members. At least one-half of such
7 members shall be medical experts (either physi-
8 cians or health care professionals).

9 “(B) LICENSURE AND EXPERTISE.—Each
10 physician or health care professional appointed
11 to an expert panel under subparagraph (A)
12 shall—

13 “(i) be appropriately credentialed or
14 licensed in one or more States to deliver
15 health care services; and

16 “(ii) typically treat the condition,
17 make the diagnosis, or provide the type of
18 treatment that is under review.

19 “(C) INDEPENDENCE.—

20 “(i) IN GENERAL.—Subject to clause
21 (ii), each individual appointed to an expert
22 panel under this paragraph shall—

23 “(I) not have a material familial,
24 financial, or professional relationship

1 with a party involved in the dispute
2 reviewed by the panel; and

3 “(II) not otherwise have a con-
4 flict of interest with such a party.

5 “(ii) EXCEPTION.—Nothing in clause
6 (i) shall be construed to prohibit an indi-
7 vidual who has staff privileges at an insti-
8 tution where the treatment involved in the
9 dispute was provided from serving as a
10 member of an expert panel merely on the
11 basis of such affiliation, if the affiliation is
12 disclosed to the parties and neither party
13 objects.

14 “(D) PRACTICING HEALTH CARE PROFES-
15 SIONAL IN SAME FIELD.—

16 “(i) IN GENERAL.—In a dispute be-
17 fore an expert panel that involves treat-
18 ment, or the provision of items or serv-
19 ices—

20 “(I) by a physician, the medical
21 experts on the expert panel shall be
22 practicing physicians (allopathic or os-
23 teopathic) of the same or similar spe-
24 cialty as a physician who typically
25 treats the condition, makes the diag-

1 nosis, or provides the type of treat-
2 ment under review; or

3 “(II) by a health care profes-
4 sional other than a physician, at least
5 two medical experts on the expert
6 panel shall be practicing physicians
7 (allopathic or osteopathic) of the same
8 or similar specialty as the health care
9 professional who typically treats the
10 condition, makes the diagnosis, or
11 provides the type of treatment under
12 review, and, if determined appropriate
13 by the State agency, an additional
14 medical expert shall be a practicing
15 health care professional (other than
16 such a physician) of such a same or
17 similar specialty.

18 “(ii) PRACTICING DEFINED.—In this
19 paragraph, the term ‘practicing’ means,
20 with respect to an individual who is a phy-
21 sician or other health care professional,
22 that the individual provides health care
23 services to individual patients on average
24 at least 2 days a week.

1 “(E) PEDIATRIC EXPERTISE.—In the case
2 of dispute relating to a child, at least 1 medical
3 expert on the expert panel shall have expertise
4 described in subparagraph (D)(i) in pediatrics.

5 “(3) DETERMINATION.—After a review under
6 paragraph (1), an expert panel shall make a deter-
7 mination as to the liability of the parties involved
8 and compensation.

9 “(4) ACCEPTANCE.—If the parties to a dispute
10 before an expert panel under this subsection accept
11 the determination of the expert panel concerning li-
12 ability and compensation, such compensation shall
13 be paid to the claimant and the claimant shall agree
14 to forgo any further action against the health care
15 providers involved.

16 “(5) FAILURE TO ACCEPT.—If any party de-
17 cides not to accept the expert panel’s determination,
18 the matter shall be referred to an administrative
19 health care tribunal created pursuant to this section.

20 “(e) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

21 “(1) IN GENERAL.—Upon the failure of any
22 party to accept the determination of an expert panel
23 under subsection (d), the parties shall have the right
24 to request a hearing concerning the liability or com-

1 pensation involved by an administrative health care
2 tribunal established by the State involved.

3 “(2) REQUIREMENTS.—In establishing an ad-
4 ministrative health care tribunal under this section,
5 a State shall—

6 “(A) ensure that such tribunals are pre-
7 sided over by special judges with health care ex-
8 pertise;

9 “(B) provide authority to such judges to
10 make binding rulings, rendered in written deci-
11 sions, on standards of care, causation, com-
12 pensation, and related issues with reliance on
13 independent expert witnesses commissioned by
14 the tribunal;

15 “(C) establish gross negligence as the legal
16 standard for the tribunal;

17 “(D) allow the admission into evidence of
18 the recommendation made by the expert panel
19 under subsection (d); and

20 “(E) provide for an appeals process to
21 allow for review of decisions by State courts.

22 “(f) REVIEW BY STATE COURT AFTER EXHAUSTION
23 OF ADMINISTRATIVE REMEDIES.—

24 “(1) RIGHT TO FILE.—If any party to a dispute
25 before a health care tribunal under subsection (e) is

1 not satisfied with the determinations of the tribunal,
2 the party shall have the right to file their claim in
3 a State court of competent jurisdiction.

4 “(2) FORFEIT OF AWARDS.—Any party filing
5 an action in a State court in accordance with para-
6 graph (1) shall forfeit any compensation award
7 made under subsection (e).

8 “(3) ADMISSIBILITY.—The determinations of
9 the expert panel and the administrative health care
10 tribunal pursuant to subsections (d) and (e) with re-
11 spect to a State court proceeding under paragraph
12 (1) shall be admissible into evidence in any such
13 State court proceeding.

14 “(g) DEFINITION.—In this section, the term ‘health
15 care provider’ means any person or entity required by
16 State or Federal laws or regulations to be licensed, reg-
17 istered, or certified to provide health care services, and
18 being either so licensed, registered, or certified, or exempt-
19 ed from such requirement by other statute or regulation.

20 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated for any fiscal year such
22 sums as may be necessary for purposes of making grants
23 to States under this section.”.

1 **SEC. 503. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**
2 **AGES TO CLAIMANTS IN HEALTH CARE LAW-**
3 **SUITS.**

4 (a) **IN GENERAL.**—In any health care lawsuit, if an
5 award of future damages, without reduction to present
6 value, equaling or exceeding \$50,000 is made against a
7 party with sufficient insurance or other assets to fund a
8 periodic payment of such a judgment, the court shall, at
9 the request of any party, enter a judgment ordering that
10 the future damages be paid by periodic payments, in ac-
11 cordance with the Uniform Periodic Payment of Judg-
12 ments Act promulgated by the National Conference of
13 Commissioners on Uniform State Laws.

14 (b) **APPLICABILITY.**—This section applies to all ac-
15 tions which have not been first set for trial or retrial be-
16 fore the effective date of this title.

17 **SEC. 504. DEFINITIONS.**

18 In this title:

19 (1) **ALTERNATIVE DISPUTE RESOLUTION SYS-**
20 **TEM; ADR.**—The term “alternative dispute resolution
21 system” or “ADR” means a system that provides
22 for the resolution of health care lawsuits in a man-
23 ner other than through a civil action brought in a
24 State or Federal court.

25 (2) **CLAIMANT.**—The term “claimant” means
26 any person who brings a health care lawsuit, includ-

1 ing a person who asserts or claims a right to legal
2 or equitable contribution, indemnity, or subrogation,
3 arising out of a health care liability claim or action,
4 and any person on whose behalf such a claim is as-
5 serted or such an action is brought, whether de-
6 ceased, incompetent, or a minor.

7 (3) FEDERAL TAX BENEFIT.—A claimant shall
8 be treated as receiving a Federal tax benefit with re-
9 spect to payment for items or services if—

10 (A) such payment is compensation by in-
11 surance—

12 (i) which constitutes medical care, and

13 (ii) with respect to the payment of
14 premiums for which the claimant, or the
15 employer of the claimant, was allowed an
16 exclusion from gross income, a deduction,
17 or a credit for Federal income tax pur-
18 poses,

19 (B) a deduction was allowed with respect
20 to such payment for Federal income tax pur-
21 poses, or

22 (C) such payment was from an Archer
23 MSA (as defined in section 220(d) of the Inter-
24 nal Revenue Code of 1986), a health savings
25 account (as defined in section 223(d) of such

1 Code), a flexible spending arrangement (as de-
2 fined in section 106(e)(2) of such Code), or a
3 health reimbursement arrangement which is
4 treated as employer-provided coverage under an
5 accident or health plan for purposes of section
6 106 of such Code.

7 (4) HEALTH CARE LAWSUIT.—The term
8 “health care lawsuit” means any health care liability
9 claim concerning the provision of health care goods
10 or services brought in a Federal court or in a State
11 court or pursuant to an alternative dispute resolu-
12 tion system, if such claim concerns items or services
13 for which coverage is provided under title XVIII,
14 XIX, or XXI of the Social Security Act or for which
15 the claimant receives a Federal tax benefit, against
16 a health care provider, a health care organization, or
17 the manufacturer, distributor, supplier, marketer,
18 promoter, or seller of a medical product, regardless
19 of the theory of liability on which the claim is based,
20 or the number of claimants, plaintiffs, defendants,
21 or other parties, or the number of claims or causes
22 of action, in which the claimant alleges a health care
23 liability claim. Such term does not include a claim
24 or action which is based on criminal liability; which

1 seeks civil fines or penalties paid to Federal govern-
2 ment; or which is grounded in antitrust.

3 (5) HEALTH CARE LIABILITY ACTION.—The
4 term “health care liability action” means a civil ac-
5 tion brought in a State or Federal court or pursuant
6 to an alternative dispute resolution system, against
7 a health care provider, a health care organization, or
8 the manufacturer, distributor, supplier, marketer,
9 promoter, or seller of a medical product, regardless
10 of the theory of liability on which the claim is based,
11 or the number of plaintiffs, defendants, or other par-
12 ties, or the number of causes of action, in which the
13 claimant alleges a health care liability claim.

14 (6) HEALTH CARE LIABILITY CLAIM.—The
15 term “health care liability claim” means a demand
16 by any person, whether or not pursuant to ADR,
17 against a health care provider, health care organiza-
18 tion, or the manufacturer, distributor, supplier, mar-
19 keter, promoter, or seller of a medical product, in-
20 cluding, but not limited to, third-party claims, cross-
21 claims, counter-claims, or contribution claims, which
22 are based upon the provision of, use of, or payment
23 for (or the failure to provide, use, or pay for) health
24 care services or medical products, regardless of the
25 theory of liability on which the claim is based, or the

1 number of plaintiffs, defendants, or other parties, or
2 the number of causes of action.

3 (7) HEALTH CARE ORGANIZATION.—The term
4 “health care organization” means any person or en-
5 tity which is obligated to provide or pay for health
6 benefits under any health plan, including any person
7 or entity acting under a contract or arrangement
8 with a health care organization to provide or admin-
9 ister any health benefit.

10 (8) HEALTH CARE PROVIDER.—The term
11 “health care provider” means any person or entity
12 required by State or Federal laws or regulations to
13 be licensed, registered, or certified to provide health
14 care services, and being either so licensed, reg-
15 istered, or certified, or exempted from such require-
16 ment by other statute or regulation.

17 (9) HEALTH CARE GOODS OR SERVICES.—The
18 term “health care goods or services” means any
19 goods or services provided by a health care organiza-
20 tion, provider, or by any individual working under
21 the supervision of a health care provider, that relates
22 to the diagnosis, prevention, or treatment of any
23 human disease or impairment, or the assessment or
24 care of the health of human beings.

1 (10) MEDICAL PRODUCT.—The term “medical
2 product” means a drug, device, or biological product
3 intended for humans, and the terms “drug”, “de-
4 vice”, and “biological product” have the meanings
5 given such terms in sections 201(g)(1) and 201(h)
6 of the Federal Food, Drug and Cosmetic Act (21
7 U.S.C. 321(g)(1) and (h)) and section 351(a) of the
8 Public Health Service Act (42 U.S.C. 262(a)), re-
9 spectively, including any component or raw material
10 used therein, but excluding health care services.

11 (11) MEDICAL TREATMENT.—The term “med-
12 ical treatment” means the provision of any goods or
13 services by a health care provider or by any indi-
14 vidual working under the supervision of a health
15 care provider, that relates to the diagnosis, preven-
16 tion, or treatment of any human disease or impair-
17 ment, or the assessment or care of the health of
18 human beings.

19 (12) RECOVERY.—The term “recovery” means
20 the net sum recovered after deducting any disburse-
21 ments or costs incurred in connection with prosecu-
22 tion or settlement of the claim, including all costs
23 paid or advanced by any person. Costs of health care
24 incurred by the plaintiff and the attorneys’ office

1 overhead costs or charges for legal services are not
2 deductible disbursements or costs for such purpose.

3 (13) STATE.—The term “State” means each of
4 the several States, the District of Columbia, the
5 Commonwealth of Puerto Rico, the Virgin Islands,
6 Guam, American Samoa, the Northern Mariana Is-
7 lands, the Trust Territory of the Pacific Islands, and
8 any other territory or possession of the United
9 States, or any political subdivision thereof.

10 **SEC. 505. EFFECT ON OTHER LAWS.**

11 (a) VACCINE INJURY.—

12 (1) To the extent that title XXI of the Public
13 Health Service Act establishes a Federal rule of law
14 applicable to a civil action brought for a vaccine-re-
15 lated injury or death—

16 (A) this title does not affect the application
17 of the rule of law to such an action; and

18 (B) any rule of law prescribed by this title
19 in conflict with a rule of law of such title XXI
20 shall not apply to such action.

21 (2) If there is an aspect of a civil action
22 brought for a vaccine-related injury or death to
23 which a Federal rule of law under title XXI of the
24 Public Health Service Act does not apply, then this
25 title or otherwise applicable law (as determined

1 under this title) will apply to such aspect of such ac-
2 tion.

3 (b) OTHER FEDERAL LAW.—Except as provided in
4 this section, nothing in this title shall be deemed to affect
5 any defense available to a defendant in a health care law-
6 suit or action under any other provision of Federal law.

7 **SEC. 506. APPLICABILITY; EFFECTIVE DATE.**

8 This title shall apply to any health care lawsuit
9 brought in a Federal or State court, or subject to an alter-
10 native dispute resolution system, that is initiated on or
11 after the date of the enactment of this title, except that
12 any health care lawsuit arising from an injury occurring
13 prior to the date of the enactment of this title shall be
14 governed by the applicable statute of limitations provisions
15 in effect at the time the injury occurred.

16 **TITLE VI—WELLNESS AND**
17 **PREVENTION**

18 **SEC. 601. PROVIDING FINANCIAL INCENTIVES FOR TREAT-**
19 **MENT COMPLIANCE.**

20 (a) LIMITATION ON EXCEPTION FOR WELLNESS
21 PROGRAMS UNDER HIPAA DISCRIMINATION RULES.—

22 (1) EMPLOYEE RETIREMENT INCOME SECURITY
23 ACT OF 1974 AMENDMENT.—Section 702(b)(2) of the
24 Employee Retirement Income Security Act of 1974

1 (29 U.S.C. 1182(b)(2)) is amended by adding after
2 and below subparagraph (B) the following:

3 “In applying subparagraph (B), a group health plan
4 (or a health insurance issuer with respect to health
5 insurance coverage) may vary premiums and cost-
6 sharing by up to 50 percent of the value of the bene-
7 fits under the plan (or coverage) based on participa-
8 tion (or lack of participation) in a standards-based
9 wellness program.”.

10 (2) PHSA AMENDMENT.—Section 2702(b)(2)
11 of the Public Health Service Act (42 U.S.C. 300gg-
12 1(b)(2)) is amended by adding after and below sub-
13 paragraph (B) the following:

14 “In applying subparagraph (B), a group health plan
15 (or a health insurance issuer with respect to health
16 insurance coverage) may vary premiums and cost-
17 sharing by up to 50 percent of the value of the bene-
18 fits under the plan (or coverage) based on participa-
19 tion (or lack of participation) in a standards-based
20 wellness program.”.

21 (3) IRC AMENDMENT.—Section 9802(b)(2) of
22 the Internal Revenue Code of 1986 is amended by
23 adding after and below subparagraph (B) the fol-
24 lowing:

1 “In applying subparagraph (B), a group health plan
2 may vary premiums and cost-sharing by up to 50
3 percent of the value of the benefits under the plan
4 based on participation (or lack of participation) in a
5 standards-based wellness program.”.

6 (b) EFFECTIVE DATE.—The amendments made by
7 subsection (a) shall apply to plan years beginning more
8 than 1 year after the date of the enactment of this Act.

9 **TITLE VII—TRANSPARENCY AND**
10 **INSURANCE REFORM MEASURES**

11 **SEC. 701. RECEIPT AND RESPONSE TO REQUESTS FOR**
12 **CLAIM INFORMATION.**

13 (a) IN GENERAL.—Title XXVII of the Public Health
14 Service Act is amended by inserting after section 2713 the
15 following new section:

16 **“SEC. 2714. RECEIPT AND RESPONSE TO REQUESTS FOR**
17 **CLAIM INFORMATION.**

18 “(a) REQUIREMENT.—

19 “(1) IN GENERAL.—In the case of health insur-
20 ance coverage offered in connection with a group
21 health plan, not later than the 30th day after the
22 date a health insurance issuer receives a written re-
23 quest for a written report of claim information from
24 the plan, plan sponsor, or plan administrator, the
25 health insurance issuer shall provide the requesting

1 party the report, subject to the succeeding provisions
2 of this section.

3 “(2) EXCEPTION.—The health insurance issuer
4 is not obligated to provide a report under this sub-
5 section regarding a particular employer or group
6 health plan more than twice in any 12-month period
7 and is not obligated to provide such a report in the
8 case of an employer with fewer than 50 employees.

9 “(3) DEADLINE.—A plan, plan sponsor, or plan
10 administrator must request a report under this sub-
11 section before or on the second anniversary of the
12 date of termination of coverage under a group health
13 plan issued by the health insurance issuer.

14 “(b) FORM OF REPORT; INFORMATION TO BE IN-
15 CLUDED.—

16 “(1) IN GENERAL.—A health insurance issuer
17 shall provide the report of claim information under
18 subsection (a)—

19 “(A) in a written report;

20 “(B) through an electronic file transmitted
21 by secure electronic mail or a file transfer pro-
22 tocol site; or

23 “(C) by making the required information
24 available through a secure Web site or Web por-

1 tal accessible by the requesting plan, plan spon-
2 sor, or plan administrator.

3 “(2) INFORMATION TO BE INCLUDED.—A re-
4 port of claim information provided under subsection
5 (a) shall contain all information available to the
6 health insurance issuer that is responsive to the re-
7 quest made under such subsection, including, subject
8 to subsection (c), protected health information, for
9 the 36-month period preceding the date of the report
10 or the period specified by subparagraphs (D), (E),
11 and (F) of paragraph (3), if applicable, or for the
12 entire period of coverage, whichever period is short-
13 er.

14 “(3) REQUIRED INFORMATION.—Subject to
15 subsection (c), a report provided under subsection
16 (a) shall include the following:

17 “(A) Aggregate paid claims experience by
18 month, including claims experience for medical,
19 dental, and pharmacy benefits, as applicable.

20 “(B) Total premium paid by month.

21 “(C) Total number of covered employees
22 on a monthly basis by coverage tier, including
23 whether coverage was for—

24 “(i) an employee only;

1 “(ii) an employee with dependents
2 only;

3 “(iii) an employee with a spouse only;
4 or

5 “(iv) an employee with a spouse and
6 dependents.

7 “(D) The total dollar amount of claims
8 pending as of the date of the report.

9 “(E) A separate description and individual
10 claims report for any individual whose total
11 paid claims exceed \$15,000 during the 12-
12 month period preceding the date of the report,
13 including the following information related to
14 the claims for that individual—

15 “(i) a unique identifying number,
16 characteristic, or code for the individual;

17 “(ii) the amounts paid;

18 “(iii) dates of service; and

19 “(iv) applicable procedure codes and
20 diagnosis codes.

21 “(F) For claims that are not part of the
22 information described in a previous subpara-
23 graph, a statement describing precertification
24 requests for hospital stays of 5 days or longer

1 that were made during the 30-day period pre-
2 ceding the date of the report.

3 “(c) LIMITATIONS ON DISCLOSURE.—

4 “(1) IN GENERAL.—A health insurance issuer
5 may not disclose protected health information in a
6 report of claim information provided under this sec-
7 tion if the health insurance issuer is prohibited from
8 disclosing that information under another State or
9 Federal law that imposes more stringent privacy re-
10 strictions than those imposed under Federal law
11 under the HIPAA privacy regulations. To withhold
12 information in accordance with this subsection, the
13 health insurance issuer must—

14 “(A) notify the plan, plan sponsor, or plan
15 administrator requesting the report that infor-
16 mation is being withheld; and

17 “(B) provide to the plan, plan sponsor, or
18 plan administrator a list of categories of claim
19 information that the health insurance issuer has
20 determined are subject to the more stringent
21 privacy restrictions under another State or Fed-
22 eral law.

23 “(2) PROTECTION.—A plan sponsor is entitled
24 to receive protected health information under sub-
25 paragraph (E) and (F) of subsection (b)(3) and sub-

1 section (d) only after an appropriately authorized
2 representative of the plan sponsor makes to the
3 health insurance issuer a certification substantially
4 similar to the following certification: ‘I hereby certify
5 that the plan documents comply with the require-
6 ments of section 164.504(f)(2) of title 45, Code of
7 Federal Regulations, and that the plan sponsor will
8 safeguard and limit the use and disclosure of pro-
9 tected health information that the plan sponsor may
10 receive from the group health plan to perform the
11 plan administration functions.’.

12 “(3) RESULTS.—A plan sponsor that does not
13 provide the certification required by paragraph (2) is
14 not entitled to receive the protected health informa-
15 tion described by subparagraphs (E) and (F) of sub-
16 section (b)(3) and subsection (d), but is entitled to
17 receive a report of claim information that includes
18 the information described by subparagraphs (A)
19 through (D) of subsection (b)(3).

20 “(4) INFORMATION.—In the case of a request
21 made under subsection (a) after the date of termi-
22 nation of coverage, the report must contain all infor-
23 mation available to the health insurance issuer as of
24 the date of the report that is responsive to the re-
25 quest, including protected health information, and

1 including the information described by subsection
2 (b)(3), for the period described by subsection (b)(2)
3 preceding the date of termination of coverage or for
4 the entire policy period, whichever period is shorter.
5 Notwithstanding this subsection, the report may not
6 include the protected health information described
7 by subparagraphs (E) and (F) of subsection (b)(3)
8 unless a certification has been provided in accord-
9 ance with paragraph (2).

10 “(d) REQUEST FOR ADDITIONAL INFORMATION.—

11 “(1) REVIEW.—On receipt of the report re-
12 quired by subsection (a), the plan, plan sponsor, or
13 plan administrator may review the report and, not
14 later than the 10th day after the date the report is
15 received, may make a written request to the health
16 insurance issuer for additional information in ac-
17 cordance with this subsection for specified individ-
18 uals.

19 “(2) REQUEST.—With respect to a request for
20 additional information concerning specified individ-
21 uals for whom claims information has been provided
22 under subsection (b)(3)(E), the health insurance
23 issuer shall provide additional information on the
24 prognosis or recovery if available and, for individuals
25 in active case management, the most recent case

1 management information, including any future ex-
2 pected costs and treatment plan, that relate to the
3 claims for that individual.

4 “(3) RESPONSE.—The health insurance issuer
5 must respond to the request for additional informa-
6 tion under this subsection not later than the 15th
7 day after the date of such request unless the re-
8 questing plan, plan sponsor, or plan administrator
9 agrees to a request for additional time.

10 “(4) LIMITATION.—The health insurance issuer
11 is not required to produce the report described by
12 this subsection unless a certification has been pro-
13 vided in accordance with subsection (c)(2).

14 “(5) COMPLIANCE WITH SECTION DOES NOT
15 CREATE LIABILITY.—A health insurance issuer that
16 releases information, including protected health in-
17 formation, in accordance with this subsection has
18 not violated a standard of care and is not liable for
19 civil damages resulting from, and is not subject to
20 criminal prosecution for, releasing that information.

21 “(e) LIMITATION ON PREEMPTION.—Nothing in this
22 section is meant to limit States from enacting additional
23 laws in addition to the provisions of this section, but not
24 in lieu of such provisions.

25 “(f) DEFINITIONS.—In this section:

1 “(1) The terms ‘employer’, ‘plan administrator’,
2 and ‘plan sponsor’ have the meanings given such
3 terms in section 3 of the Employee Retirement In-
4 come Security Act of 1974.

5 “(2) The term ‘HIPAA privacy regulations’ has
6 the meaning given such term in section 1180(b)(3)
7 of the Social Security Act.

8 “(3) The term ‘protected health information’
9 has the meaning given such term under the HIPAA
10 privacy regulations.”.

11 (b) EFFECTIVE DATE.—The amendment made by
12 subsection (a) shall take effect on the date of the enact-
13 ment of this Act.

14 **TITLE VIII—QUALITY**

15 **SEC. 801. PROHIBITION ON CERTAIN USES OF DATA OB-**
16 **TAINED FROM COMPARATIVE EFFECTIVE-**
17 **NESS RESEARCH OR FROM PATIENT-CEN-**
18 **TERED OUTCOMES RESEARCH; ACCOUNTING**
19 **FOR PERSONALIZED MEDICINE AND DIF-**
20 **FERENCES IN PATIENT TREATMENT RE-**
21 **SPONSE.**

22 (a) IN GENERAL.—Notwithstanding any other provi-
23 sion of law, the Secretary of Health and Human Serv-
24 ices—

1 (1) shall not use data obtained from the con-
2 duct of comparative effectiveness research or pa-
3 tient-centered outcomes research, including such re-
4 search that is conducted or supported using funds
5 appropriated under the American Recovery and Re-
6 investment Act of 2009 (Public Law 111–5), to deny
7 coverage of an item or service under a Federal
8 health care program (as defined in section 1128B(f)
9 of the Social Security Act (42 U.S.C. 1320a–7b(f)));
10 and

11 (2) shall ensure that comparative effectiveness
12 research and patient-centered outcomes research
13 conducted or supported by the Federal Government
14 accounts for factors contributing to differences in
15 the treatment response and treatment preferences of
16 patients, including patient-reported outcomes,
17 genomics and personalized medicine, the unique
18 needs of health disparity populations, and indirect
19 patient benefits.

20 (b) CONSULTATION AND APPROVAL REQUIRED.—
21 Nothing the Federal Coordinating Council for Compara-
22 tive Effectiveness Research finds can be released in final
23 form until after consultation with and approved by rel-
24 evant physician specialty organizations.

1 (c) RULE OF CONSTRUCTION.—Nothing in this sec-
2 tion shall be construed as affecting the authority of the
3 Commissioner of Food and Drugs under the Federal
4 Food, Drug, and Cosmetic Act or the Public Health Serv-
5 ice Act.

6 **SEC. 802. ESTABLISHMENT OF PERFORMANCE-BASED**
7 **QUALITY MEASURES.**

8 Not later than January 1, 2014, the Secretary of
9 Health and Human Services shall submit to Congress a
10 proposal for a formalized process for the development of
11 performance-based quality measures that could be applied
12 to physicians' services under the Medicare program under
13 title XVIII of the Social Security Act. Such proposal shall
14 be in concert and agreement with the Physician Consor-
15 tium for Performance Improvement and shall only utilize
16 measures agreed upon by each physician specialty organi-
17 zation.

18 **TITLE IX—STATE**
19 **TRANSPARENCY PLAN PORTAL**

20 **SEC. 901. PROVIDING INFORMATION ON HEALTH COV-**
21 **ERAGE OPTIONS AND HEALTH CARE PRO-**
22 **VIDERS.**

23 (a) STATE-BASED PORTAL.—A State (by itself or
24 jointly with other States) may contract with a private enti-
25 ty to establish a Health Plan and Provider Portal Web

1 site (referred to in this section as a “plan portal”) for
2 the purposes of providing standardized information—

3 (1) on health insurance plans that have been
4 certified to be available for purchase in that State;
5 and

6 (2) on price and quality information on health
7 care providers (including physicians, hospitals, and
8 other health care institutions).

9 (b) PROHIBITIONS.—

10 (1) DIRECT ENROLLMENT.—A plan portal may
11 not directly enroll individuals in health insurance
12 plans or under a State Medicaid plan or a State
13 children’s health insurance plan.

14 (2) CONFLICTS OF INTEREST.—

15 (A) COMPANIES.—A health insurance
16 issuer offering a health insurance plan through
17 a plan portal may not—

18 (i) be the private entity developing
19 and maintaining a plan portal under this
20 section; or

21 (ii) have an ownership interest in such
22 private entity or in the plan portal.

23 (B) INDIVIDUALS.—An individual em-
24 ployed by a health insurance issuer offering a

1 health insurance plan through a plan portal
2 may not serve as a director or officer for—

3 (i) the private entity developing and
4 maintaining a plan portal under this sec-
5 tion; or

6 (ii) the plan portal.

7 (c) CONSTRUCTION.—Nothing in this section shall be
8 construed to prohibit health insurance brokers and agents
9 from—

10 (1) utilizing the plan portal for any purpose; or

11 (2) marketing or offering health insurance
12 products.

13 (d) STATE DEFINED.—In this section, the term
14 “State” has the meaning given such term for purposes of
15 title XIX of the Social Security Act.

16 (e) HEALTH INSURANCE PLANS.—For purposes of
17 this section, the term “health insurance plan” does not
18 include coverage of excepted benefits, as defined in section
19 2791(c) of the Public Health Service Act (42 U.S.C.
20 300gg–91(e)).

1 **TITLE X—PATIENT FREEDOM OF**
2 **CHOICE**

3 **SEC. 1001. GUARANTEEING FREEDOM OF CHOICE AND CON-**
4 **TRACTING FOR PATIENTS UNDER MEDICARE.**

5 (a) IN GENERAL.—Section 1802 of the Social Secu-
6 rity Act (42 U.S.C. 1395a) is amended to read as follows:

7 “FREEDOM OF CHOICE AND CONTRACTING BY PATIENT
8 GUARANTEED

9 “SEC. 1802. (a) BASIC FREEDOM OF CHOICE.—Any
10 individual entitled to insurance benefits under this title
11 may obtain health services from any institution, agency,
12 or person qualified to participate under this title if such
13 institution, agency, or person undertakes to provide that
14 individual such services.

15 “(b) FREEDOM TO CONTRACT BY MEDICARE BENE-
16 FICIARIES.—

17 “(1) IN GENERAL.—Subject to the provisions of
18 this subsection, nothing in this title shall prohibit a
19 Medicare beneficiary from entering into a contract
20 with an eligible professional (whether or not the pro-
21 fessional is a participating or non-participating phy-
22 sician or practitioner) for any item or service cov-
23 ered under this title.

24 “(2) SUBMISSION OF CLAIMS.—Any Medicare
25 beneficiary that enters into a contract under this

1 section with an eligible professional shall be per-
2 mitted to submit a claim for payment under this
3 title for services furnished by such professional, and
4 such payment shall be made in the amount that
5 would otherwise apply to such professional under
6 this title except that where such professional is con-
7 sidered to be non-participating, payment shall be
8 paid as if the professional were participating. Pay-
9 ment made under this title for any item or service
10 provided under the contract shall not render the pro-
11 fessional a participating or non-participating physi-
12 cian or practitioner, and as such, requirements of
13 this title that may otherwise apply to a participating
14 or non-participating physician or practitioner would
15 not apply with respect to any items or services fur-
16 nished under the contract.

17 “(3) BENEFICIARY PROTECTIONS.—

18 “(A) IN GENERAL.—Paragraph (1) shall
19 not apply to any contract unless—

20 “(i) the contract is in writing, is
21 signed by the Medicare beneficiary and the
22 eligible professional, and establishes all
23 terms of the contract (including specific
24 payment for items and services covered by
25 the contract) before any item or service is

1 provided pursuant to the contract, and the
2 beneficiary shall be held harmless for any
3 subsequent payment charged for an item
4 or service in excess of the amount estab-
5 lished under the contract during the period
6 the contract is in effect;

7 “(ii) the contract contains the items
8 described in subparagraph (B); and

9 “(iii) the contract is not entered into
10 at a time when the Medicare beneficiary is
11 facing an emergency medical condition or
12 urgent health care situation.

13 “(B) ITEMS REQUIRED TO BE INCLUDED
14 IN CONTRACT.—Any contract to provide items
15 and services to which paragraph (1) applies
16 shall clearly indicate to the Medicare beneficiary
17 that by signing such contract the beneficiary—

18 “(i) agrees to be responsible for pay-
19 ment to such eligible professional for such
20 items or services under the terms of and
21 amounts established under the contract;

22 “(ii) agrees to be responsible for sub-
23 mitting claims under this title to the Sec-
24 retary, and to any other supplemental in-
25 surance plan that may provide supple-

1 mental insurance, for such items or serv-
2 ices furnished under the contract if such
3 items or services are covered by this title,
4 unless otherwise provided in the contract
5 under subparagraph (C)(i); and

6 “(iii) acknowledges that no limits or
7 other payment incentives that may other-
8 wise apply under this title (such as the
9 limits under subsection (g) of section 1848
10 or incentives under subsection (a)(5), (m),
11 (q), and (p) of such section) shall apply to
12 amounts that may be charged, or paid to
13 a beneficiary for, such items or services.

14 Such contract shall also clearly indicate whether
15 the eligible professional is excluded from par-
16 ticipation under the Medicare program under
17 section 1128.

18 “(C) BENEFICIARY ELECTIONS UNDER
19 THE CONTRACT.—Any Medicare beneficiary
20 that enters into a contract under this section
21 may elect to negotiate, as a term of the con-
22 tract, a provision under which—

23 “(i) the eligible professional shall file
24 claims on behalf of the beneficiary with the
25 Secretary and any supplemental insurance

1 plan for items or services furnished under
2 the contract if such items or services are
3 covered under this title or under the plan;
4 and

5 “(ii) the beneficiary assigns payment
6 to the eligible professional for any claims
7 filed by, or on behalf of, the beneficiary
8 with the Secretary and any supplemental
9 insurance plan for items or services fur-
10 nished under the contract.

11 “(D) EXCLUSION OF DUAL ELIGIBLE INDI-
12 VIDUALS.—Paragraph (1) shall not apply to
13 any contract if a beneficiary who is eligible for
14 medical assistance under title XIX is a party to
15 the contract.

16 “(4) LIMITATION ON ACTUAL CHARGE AND
17 CLAIM SUBMISSION REQUIREMENT NOT APPLICA-
18 BLE.—Section 1848(g) shall not apply with respect
19 to any item or service provided to a Medicare bene-
20 ficiary under a contract described in paragraph (1).

21 “(5) CONSTRUCTION.—Nothing in this section
22 shall be construed—

23 “(A) to prohibit any eligible professional
24 from maintaining an election and acting as a
25 participating or non-participating physician or

1 practitioner with respect to any patient not cov-
2 ered under a contract established under this
3 section; and

4 “(B) as changing the items and services
5 for which an eligible professional may bill under
6 this title.

7 “(6) DEFINITIONS.—In this subsection:

8 “(A) MEDICARE BENEFICIARY.—The term
9 ‘Medicare beneficiary’ means an individual who
10 is entitled to benefits under part A or enrolled
11 under part B.

12 “(B) ELIGIBLE PROFESSIONAL.—The term
13 ‘eligible professional’ has the meaning given
14 such term in section 1848(k)(3)(B).

15 “(C) EMERGENCY MEDICAL CONDITION.—
16 The term ‘emergency medical condition’ means
17 a medical condition manifesting itself by acute
18 symptoms of sufficient severity (including se-
19 vere pain) such that a prudent layperson, with
20 an average knowledge of health and medicine,
21 could reasonably expect the absence of imme-
22 diate medical attention to result in—

23 “(i) serious jeopardy to the health of
24 the individual or, in the case of a pregnant

1 woman, the health of the woman or her
2 unborn child;

3 “(ii) serious impairment to bodily
4 functions; or

5 “(iii) serious dysfunction of any bodily
6 organ or part.

7 “(D) URGENT HEALTH CARE SITUA-
8 TION.—The term ‘urgent health care situation’
9 means services furnished to an individual who
10 requires services to be furnished within 12
11 hours in order to avoid the likely onset of an
12 emergency medical condition.”.

13 **SEC. 1002. PREEMPTION OF STATE LAWS LIMITING**
14 **CHARGES FOR ELIGIBLE PROFESSIONAL**
15 **SERVICES.**

16 (a) IN GENERAL.—No State may impose a limit on
17 the amount of charges for services, furnished by an eligible
18 professional (as defined in subsection (k)(3)(B) of section
19 1848 of the Social Security Act, 42 U.S.C. 1395w-4), for
20 which payment is made under such section, and any such
21 limit is hereby preempted.

22 (b) STATE.—In this section, the term “State” in-
23 cludes the District of Columbia, Puerto Rico, the Virgin
24 Islands, Guam, and American Samoa.

1 **SEC. 1003. HEALTH CARE PROVIDER LICENSURE CANNOT**
2 **BE CONDITIONED ON PARTICIPATION IN A**
3 **HEALTH PLAN.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services and any State (as a condition of receiving
6 Federal financial participation under title XIX of the So-
7 cial Security Act) may not require any health care pro-
8 vider to participate in any health plan as a condition of
9 licensure of the provider in any State.

10 (b) DEFINITIONS.—In this section:

11 (1) HEALTH PLAN.—The term “health plan”
12 has the meaning given such term in section 1171(5)
13 of the Social Security Act (42 U.S.C. 1320d(5)).

14 (2) HEALTH CARE PROVIDER.—The term
15 “health care provider” means any person or entity
16 that is required by State or Federal laws or regula-
17 tions to be licensed, registered, or certified to pro-
18 vide health care services and is so licensed, reg-
19 istered, or certified, or exempted from such require-
20 ment by other statute or regulation.

21 (3) STATE.—The term “State” has the mean-
22 ing given such term for purposes of title XIX of the
23 Social Security Act.

1 **SEC. 1004. BAD DEBT DEDUCTION FOR DOCTORS TO PAR-**
2 **TIALLY OFFSET THE COST OF PROVIDING UN-**
3 **COMPENSATED CARE REQUIRED TO BE PRO-**
4 **VIDED UNDER AMENDMENTS MADE BY THE**
5 **EMERGENCY MEDICAL TREATMENT AND**
6 **LABOR ACT.**

7 (a) IN GENERAL.—Section 166 of the Internal Rev-
8 enue Code of 1986 (relating to bad debts) is amended by
9 redesignating subsection (f) as subsection (g) and by in-
10 serting after subsection (e) the following new subsection:

11 “(f) BAD DEBT TREATMENT FOR DOCTORS TO PAR-
12 TIALLY OFFSET COST OF PROVIDING UNCOMPENSATED
13 CARE REQUIRED TO BE PROVIDED.—

14 “(1) AMOUNT OF DEDUCTION.—

15 “(A) IN GENERAL.—For purposes of sub-
16 section (a), the basis for determining the
17 amount of any deduction for an eligible
18 EMTALA debt shall be treated as being equal
19 to the Medicare payment amount.

20 “(B) MEDICARE PAYMENT AMOUNT.—For
21 purposes of subparagraph (A), the Medicare
22 payment amount with respect to an eligible
23 EMTALA debt is the fee schedule amount es-
24 tablished under section 1848 of the Social Secu-
25 rity Act for the physicians’ service (to which
26 such debt relates) as if the service were pro-

1 vided to an individual enrolled under part B of
2 title XVIII of such Act.

3 “(2) ELIGIBLE EMTALA DEBT.—For purposes
4 of this section, the term ‘eligible EMTALA debt’
5 means any debt if—

6 “(A) such debt arose as a result of physi-
7 cians’ services—

8 “(i) which were performed in an
9 EMTALA hospital by a board-certified
10 physician (whether as part of medical
11 screening or necessary stabilizing treat-
12 ment and whether as an emergency depart-
13 ment physician, as an on-call physician, or
14 otherwise), and

15 “(ii) which were required to be pro-
16 vided under section 1867 of the Social Se-
17 curity Act (42 U.S.C. 1395dd), and

18 “(B) such debt is owed—

19 “(i) to such physician, or

20 “(ii) to an entity if—

21 “(I) such entity is a corporation
22 and the sole shareholder of such cor-
23 poration is such physician, or

24 “(II) such entity is a partnership
25 and any deduction under this sub-

1 section with respect to such debt is al-
2 located to such physician or to an en-
3 tity described in subclause (I).

4 “(3) BOARD-CERTIFIED PHYSICIAN.—For pur-
5 poses of this subsection, the term ‘board-certified
6 physician’ means any physician (as defined in sec-
7 tion 1861(r) of the Social Security Act (42 U.S.C.
8 1395x(r))) who is certified by the American Board
9 of Emergency Medicine or other appropriate medical
10 specialty board for the specialty in which the physi-
11 cian practices, or who meets comparable require-
12 ments, as identified by the Secretary of the Treasury
13 in consultation with Secretary of Health and Human
14 Services.

15 “(4) OTHER DEFINITIONS.—For purposes of
16 this subsection—

17 “(A) EMTALA HOSPITAL.—The term
18 ‘EMTALA hospital’ means any hospital having
19 a hospital emergency department which is re-
20 quired to comply with section 1867 of the So-
21 cial Security Act (42 U.S.C. 1395dd) (relating
22 to examination and treatment for emergency
23 medical conditions and women in labor).

24 “(B) PHYSICIANS’ SERVICES.—The term
25 ‘physicians’ services’ has the meaning given

1 (2) EXCLUSION OF MEDICAID AND TRICARE.—

2 Such term does not include a health plan partici-
3 pating in—

4 (A) the Medicaid program under title XIX
5 of the Social Security Act; or

6 (B) the TRICARE program under chapter
7 55 of title 10, United States Code.

8 (c) HEALTH CARE PROVIDER DEFINED.—In this
9 section, the term “health care provider” means—

10 (1) a physician, as defined in paragraphs (1),
11 (2), (3), and (4) of section 1861(r) of the Social Se-
12 curity Act (42 U.S.C. 1395x(r)); and

13 (2) a health care practitioner described in sec-
14 tion 1842(b)(18)(C) of such Act (42 U.S.C.
15 1395u(b)(18)(C)).

16 **TITLE XI—INCENTIVES TO**
17 **REDUCE PHYSICIAN SHORTAGES**
18 **Subtitle A—Federally Supported**
19 **Student Loan Funds for Medical**
20 **Students**

21 **SEC. 1101. FEDERALLY SUPPORTED STUDENT LOAN FUNDS**
22 **FOR MEDICAL STUDENTS.**

23 (a) PRIMARY HEALTH CARE MEDICAL STUDENTS.—
24 Subpart II of part A of the Public Health Service Act (42
25 U.S.C. 292q et seq.) is amended—

1 (1) by redesignating section 735 as section 729;
2 and

3 (2) in subsection (f) of section 729 (as so redesi-
4 gnated), by striking “is authorized to be appro-
5 priated \$10,000,000 for each of the fiscal years
6 1994 through 1996” and inserting “are authorized
7 to be appropriated such sums as may be necessary
8 for fiscal year 2014 and each fiscal year thereafter”.

9 (b) OTHER MEDICAL STUDENTS.—Part A of title VII
10 of the Public Health Service Act (42 U.S.C. 292 et seq.)
11 is amended by adding at the end the following:

12 **“Subpart III—Federally Supported Student Loan**

13 **Funds for Certain Medical Students**

14 **“SEC. 730. SCHOOL LOAN FUNDS FOR CERTAIN MEDICAL**
15 **STUDENTS.**

16 “(a) FUND AGREEMENTS.—For the purpose de-
17 scribed in subsection (b), the Secretary is authorized to
18 enter into an agreement for the establishment and oper-
19 ation of a student loan fund with any public or nonprofit
20 school of medicine or osteopathic medicine.

21 “(b) PURPOSE.—The purpose of this subpart is to
22 provide for loans to medical students who would be eligible
23 for a loan under subpart II, except for the student’s deci-
24 sion to enter a residency training program in a field other
25 than primary health care.

1 “(c) COMMENCEMENT OF REPAYMENT PERIOD.—

2 The repayment period for a loan under this section shall
3 not begin before the end of any period during which the
4 student is participating in an internship, residency, or fel-
5 lowship training program directly related to the field of
6 medicine which the student agrees to enter pursuant to
7 subsection (d).

8 “(d) REQUIREMENTS FOR STUDENTS.—Each agree-
9 ment under this section for the establishment of a student
10 loan fund shall provide that the school of medicine or os-
11 teopathic medicine will make a loan to a student from such
12 fund only if the student agrees—

13 “(1) to enter and complete a residency training
14 program (in a field of medicine other than primary
15 health care) not later than a period determined by
16 the Secretary to be reasonable after the date on
17 which the student graduates from such school; and

18 “(2) to practice medicine through the date on
19 which the loan is repaid in full.

20 “(e) REQUIREMENTS FOR SCHOOLS.—The provisions
21 of section 723(b) (regarding graduates in primary health
22 care) shall not apply to a student loan fund established
23 under this section.

24 “(f) APPLICABILITY OF OTHER PROVISIONS.—Ex-
25 cept as inconsistent with this section, the provisions of

1 subpart II shall apply to the program of student loan
2 funds established under this section to the same extent
3 and in the same manner as such provisions apply to the
4 program of student loan funds established under subpart
5 II.

6 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
7 carry out this section, there are authorized to be appro-
8 priated such sums as may be necessary for fiscal year
9 2014 and each fiscal year thereafter.”.

10 **Subtitle B—Loan Forgiveness for** 11 **Primary Care Providers**

12 **SEC. 1111. LOAN FORGIVENESS FOR PRIMARY CARE PRO-** 13 **VIDERS.**

14 (a) IN GENERAL.—The Secretary of Health and
15 Human Services shall carry out a program of entering into
16 contracts with eligible individuals under which—

17 (1) the individual agrees to serve for a period
18 of not less than 5 years as a primary care provider;
19 and

20 (2) in consideration of such service, the Sec-
21 retary agrees to pay not more than \$50,000 on the
22 principal and interest on the individual’s graduate
23 educational loans.

24 (b) ELIGIBILITY.—To be eligible to enter into a con-
25 tract under subsection (a), an individual must—

1 (1) have a graduate degree in medicine, osteo-
2 pathic medicine, or another health profession from
3 an accredited (as determined by the Secretary of
4 Health and Human Services) institution of higher
5 education; and

6 (2) have practiced as a primary care provider
7 for a period (excluding any residency or fellowship
8 training period) of not less than—

9 (A) 5 years; or

10 (B) 3 years in a medically underserved
11 community (as defined in section 799B of the
12 Public Health Service Act (42 U.S.C. 295p)).

13 (c) INSTALLMENTS.—Payments under this section
14 may be made in installments of not more than \$10,000
15 for each year of service described in subsection (a)(1).

16 (d) APPLICABILITY OF CERTAIN PROVISIONS.—The
17 provisions of subpart III of part D of title III of the Public
18 Health Service Act shall, except as inconsistent with this
19 section, apply to the program established under this sec-
20 tion in the same manner and to the same extent as such
21 provisions apply to the National Health Service Corps
22 Loan Repayment Program established in such subpart.

1 **TITLE XII—QUALITY HEALTH**
2 **CARE COALITION**

3 **SEC. 1201. QUALITY HEALTH CARE COALITION.**

4 (a) APPLICATION OF THE FEDERAL ANTITRUST
5 LAWS TO HEALTH CARE PROFESSIONALS NEGOTIATING
6 WITH HEALTH PLANS.—

7 (1) IN GENERAL.—Any health care profes-
8 sionals who are engaged in negotiations with a
9 health plan regarding the terms of any contract
10 under which the professionals provide health care
11 items or services for which benefits are provided
12 under such plan shall, in connection with such nego-
13 tiations, be exempt from the Federal antitrust laws.

14 (2) LIMITATION.—

15 (A) NO NEW RIGHT FOR COLLECTIVE CES-
16 SATION OF SERVICE.—The exemption provided
17 in paragraph (1) shall not confer any new right
18 to participate in any collective cessation of serv-
19 ice to patients not already permitted by existing
20 law.

21 (B) NO CHANGE IN NATIONAL LABOR RE-
22 LATIONS ACT.—This section applies only to
23 health care professionals excluded from the Na-
24 tional Labor Relations Act. Nothing in this sec-
25 tion shall be construed as changing or amend-

1 ing any provision of the National Labor Rela-
2 tions Act, or as affecting the status of any
3 group of persons under that Act.

4 (3) NO APPLICATION TO FEDERAL PRO-
5 GRAMS.—Nothing in this section shall apply to nego-
6 tiations between health care professionals and health
7 plans pertaining to benefits provided under any of
8 the following:

9 (A) The Medicare Program under title
10 XVIII of the Social Security Act (42 U.S.C.
11 1395 et seq.).

12 (B) The Medicaid program under title XIX
13 of the Social Security Act (42 U.S.C. 1396 et
14 seq.).

15 (C) The SCHIP program under title XXI
16 of the Social Security Act (42 U.S.C. 1397aa et
17 seq.).

18 (D) Chapter 55 of title 10, United States
19 Code (relating to medical and dental care for
20 members of the uniformed services).

21 (E) Chapter 17 of title 38, United States
22 Code (relating to Veterans' medical care).

23 (F) Chapter 89 of title 5, United States
24 Code (relating to the Federal employees' health
25 benefits program).

1 (G) The Indian Health Care Improvement
2 Act (25 U.S.C. 1601 et seq.).

3 (b) DEFINITIONS.—In this section, the following defi-
4 nitions shall apply:

5 (1) ANTITRUST LAWS.—The term “antitrust
6 laws”—

7 (A) has the meaning given it in subsection
8 (a) of the first section of the Clayton Act (15
9 U.S.C. 12(a)), except that such term includes
10 section 5 of the Federal Trade Commission Act
11 (15 U.S.C. 45) to the extent such section ap-
12 plies to unfair methods of competition; and

13 (B) includes any State law similar to the
14 laws referred to in subparagraph (A).

15 (2) GROUP HEALTH PLAN.—The term “group
16 health plan” means an employee welfare benefit plan
17 to the extent that the plan provides medical care (in-
18 cluding items and services paid for as medical care)
19 to employees or their dependents (as defined under
20 the terms of the plan) directly or through insurance,
21 reimbursement, or otherwise.

22 (3) GROUP HEALTH PLAN, HEALTH INSURANCE
23 ISSUER.—The terms “group health plan” and
24 “health insurance issuer” include a third-party ad-

1 administrator or other person acting for or on behalf
2 of such plan or issuer.

3 (4) HEALTH CARE SERVICES.—The term
4 “health care services” means any services for which
5 payment may be made under a health plan, includ-
6 ing services related to the delivery or administration
7 of such services.

8 (5) HEALTH CARE PROFESSIONAL.—The term
9 “health care professional” means any individual or
10 entity that provides health care items or services,
11 treatment, assistance with activities of daily living,
12 or medications to patients and who, to the extent re-
13 quired by State or Federal law, possesses specialized
14 training that confers expertise in the provision of
15 such items or services, treatment, assistance, or
16 medications.

17 (6) HEALTH INSURANCE COVERAGE.—The term
18 “health insurance coverage” means benefits con-
19 sisting of medical care (provided directly, through
20 insurance or reimbursement, or otherwise and in-
21 cluding items and services paid for as medical care)
22 under any hospital or medical service policy or cer-
23 tificate, hospital or medical service plan contract, or
24 health maintenance organization contract offered by
25 a health insurance issuer.

1 (7) HEALTH INSURANCE ISSUER.—The term
2 “health insurance issuer” means an insurance com-
3 pany, insurance service, or insurance organization
4 (including a health maintenance organization) that
5 is licensed to engage in the business of insurance in
6 a State and that is subject to State law regulating
7 insurance. Such term does not include a group
8 health plan.

9 (8) HEALTH MAINTENANCE ORGANIZATION.—
10 The term “health maintenance organization”
11 means—

12 (A) a federally qualified health mainte-
13 nance organization (as defined in section
14 1301(a) of the Public Health Service Act (42
15 U.S.C. 300e(a)));

16 (B) an organization recognized under State
17 law as a health maintenance organization; or

18 (C) a similar organization regulated under
19 State law for solvency in the same manner and
20 to the same extent as such a health mainte-
21 nance organization.

22 (9) HEALTH PLAN.—The term “health plan”
23 means a group health plan or a health insurance
24 issuer that is offering health insurance coverage.

1 (10) MEDICAL CARE.—The term “medical
2 care” means amounts paid for—

3 (A) the diagnosis, cure, mitigation, treat-
4 ment, or prevention of disease, or amounts paid
5 for the purpose of affecting any structure or
6 function of the body; and

7 (B) transportation primarily for and essen-
8 tial to receiving items and services referred to
9 in subparagraph (A).

10 (11) PERSON.—The term “person” includes a
11 State or unit of local government.

12 (12) STATE.—The term “State” includes the
13 several States, the District of Columbia, Puerto
14 Rico, the Virgin Islands of the United States, Guam,
15 American Samoa, and the Commonwealth of the
16 Northern Mariana Islands.

17 (c) EFFECTIVE DATE.—This section shall take effect
18 on the date of the enactment of this Act and shall not
19 apply with respect to conduct occurring before such date.

1 **TITLE XIII—OFFSETS**
2 **Subtitle A—Discretionary**
3 **Spending Limits**

4 **SEC. 1301. DISCRETIONARY SPENDING LIMITS.**

5 The Balanced Budget and Emergency Deficit Control
6 Act of 1985, as amended by section 101 of the Budget
7 Control Act of 2011, is amended—

8 (1) in section 251(c) (2 U.S.C. 901(c))—

9 (A) by striking “and” at the end of para-
10 graph (9); and

11 (B) by inserting after paragraph (10) the
12 following:

13 “(11) with respect to fiscal year 2022—

14 “(A) for the security category,
15 \$662,562,510,000 in budget authority; and

16 “(B) for the nonsecurity category,
17 \$496,727,490,000 in budget authority; and

18 “(12) with respect to fiscal year 2023—

19 “(A) for the security category,
20 \$689,704,290,000 in budget authority; and

21 “(B) for the nonsecurity category,
22 \$495,325,710,000;”); and

23 (2) in section 251A(2) (2 U.S.C. 901a(2))—

1 (A) in subparagraph (B)(ii), by striking
2 “\$510,000,000,000” and inserting
3 “\$410,231,250,000”;

4 (B) in subparagraph (C)(ii), by striking
5 “\$520,000,000,000” and inserting
6 “\$424,377,360,000”;

7 (C) in subparagraph (D)(ii), by striking
8 “\$530,000,000,000” and inserting
9 “\$434,464,470,000”;

10 (D) in subparagraph (E)(ii), by striking
11 “\$541,000,000,000” and inserting
12 “\$445,368,000,000”;

13 (E) in subparagraph (F)(ii), by striking
14 “\$553,000,000,000” and inserting
15 “\$457,649,280,000”;

16 (F) in subparagraph (G)(ii), by striking
17 “\$566,000,000,000” and inserting
18 “\$472,098,360,000”;

19 (G) in subparagraph (H)(ii), by striking
20 “\$578,000,000,000” and inserting
21 “\$485,466,300,000”; and

22 (H) in subparagraph (I)(ii), by striking
23 “\$590,000,000,000” and inserting
24 “\$498,094,740,000”.

1 **Subtitle B—Savings From Health**
2 **Care Efficiencies**

3 **SEC. 1311. MEDICARE DSH REPORT AND PAYMENT ADJUST-**
4 **MENTS IN RESPONSE TO COVERAGE EXPAN-**
5 **SION.**

6 (a) DSH REPORT.—

7 (1) IN GENERAL.—Not later than January 1,
8 2018, the Secretary of Health and Human Services
9 shall submit to Congress a report on Medicare DSH
10 taking into account the impact of the health care re-
11 forms carried out under this Act in reducing the
12 number of uninsured individuals. The report shall
13 include recommendations relating to the following:

14 (A) The appropriate amount, targeting,
15 and distribution of Medicare DSH to com-
16 pensate for higher Medicare costs associated
17 with serving low-income beneficiaries (taking
18 into account variations in the empirical jus-
19 tification for Medicare DSH attributable to hos-
20 pital characteristics, including bed size), con-
21 sistent with the original intent of Medicare
22 DSH.

23 (B) The appropriate amount, targeting,
24 and distribution of Medicare DSH to hospitals

1 given their continued uncompensated care costs,
2 to the extent such costs remain.

3 (2) COORDINATION WITH MEDICAID DSH RE-
4 PORT.—The Secretary shall coordinate the report
5 under this subsection with the report on Medicaid
6 DSH under section 1322(a).

7 (b) PAYMENT ADJUSTMENTS IN RESPONSE TO COV-
8 ERAGE EXPANSION.—

9 (1) IN GENERAL.—If there is a significant de-
10 crease in the national rate of uninsurance as a result
11 of this Act (as determined under paragraph (2)(A)),
12 then the Secretary of Health and Human Services
13 shall, beginning in fiscal year 2019, implement the
14 following adjustments to Medicare DSH:

15 (A) In lieu of the amount of Medicare
16 DSH payment that would otherwise be made
17 under section 1886(d)(5)(F) of the Social Secu-
18 rity Act, the amount of Medicare DSH payment
19 shall be an amount based on the recommenda-
20 tions of the report under subsection (a)(1)(A)
21 and shall take into account variations in the
22 empirical justification for Medicare DSH attrib-
23 utable to hospital characteristics, including bed
24 size.

1 (B) Subject to paragraph (3), make an ad-
2 ditional payment to a hospital by an amount
3 that is estimated based on the amount of un-
4 compensated care provided by the hospital
5 based on criteria for uncompensated care as de-
6 termined by the Secretary, which shall exclude
7 bad debt.

8 (2) SIGNIFICANT DECREASE IN NATIONAL RATE
9 OF UNINSURANCE AS A RESULT OF THIS ACT.—For
10 purposes of this subsection—

11 (A) IN GENERAL.—There is a “significant
12 decrease in the national rate of uninsurance as
13 a result of this Act” if there is a decrease in
14 the national rate of uninsurance (as defined in
15 subparagraph (B)) from 2014 to 2016 that ex-
16 ceeds 8 percentage points.

17 (B) NATIONAL RATE OF UNINSURANCE
18 DEFINED.—The term “national rate of
19 uninsurance” means, for a year, such rate for
20 the under-65 population for the year as deter-
21 mined and published by the Bureau of the Cen-
22 sus in its Current Population Survey in or
23 about September of the succeeding year.

24 (3) UNCOMPENSATED CARE INCREASE.—

1 (A) COMPUTATION OF DSH SAVINGS.—For
2 each fiscal year (beginning with fiscal year
3 2017), the Secretary shall estimate the aggregate
4 reduction in Medicare DSH that will result
5 from the adjustment under paragraph (1)(A).

6 (B) STRUCTURE OF PAYMENT IN-
7 CREASE.—The Secretary shall compute the in-
8 crease in Medicare DSH under paragraph
9 (1)(B) for a fiscal year in accordance with a
10 formula established by the Secretary that pro-
11 vides that—

12 (i) the aggregate amount of such in-
13 crease for the fiscal year does not exceed
14 50 percent of the aggregate reduction in
15 Medicare DSH estimated by the Secretary
16 for such fiscal year; and

17 (ii) hospitals with higher levels of un-
18 compensated care receive a greater in-
19 crease.

20 (c) MEDICARE DSH.—In this section, the term
21 “Medicare DSH” means adjustments in payments under
22 section 1886(d)(5)(F) of the Social Security Act (42
23 U.S.C. 1395ww(d)(5)(F)) for inpatient hospital services
24 furnished by disproportionate share hospitals.

1 **SEC. 1312. REDUCTION IN MEDICAID DSH.**

2 (a) REPORT.—

3 (1) IN GENERAL.—Not later than January 1,
4 2018, the Secretary of Health and Human Services
5 (in this title referred to as the “Secretary”) shall
6 submit to Congress a report concerning the extent to
7 which, based upon the impact of the health care re-
8 forms carried out under this Act in reducing the
9 number of uninsured individuals, there is a contin-
10 ued role for Medicaid DSH. In preparing the report,
11 the Secretary shall consult with community-based
12 health care networks serving low-income bene-
13 ficiaries.

14 (2) MATTERS TO BE INCLUDED.—The report
15 shall include the following:

16 (A) RECOMMENDATIONS.—Recommendations regarding—

17 (i) the appropriate targeting of Med-
18 icaid DSH within States; and

19 (ii) the distribution of Medicaid DSH
20 among the States.

21 (B) SPECIFICATION OF DSH HEALTH RE-
22 FORM METHODOLOGY.—The DSH Health Re-
23 form methodology described in paragraph (2) of
24 subsection (b) for purposes of implementing the
25 requirements of such subsection.
26

1 (3) COORDINATION WITH MEDICARE DSH RE-
2 PORT.—The Secretary shall coordinate the report
3 under this subsection with the report on Medicare
4 DSH under section 1321.

5 (4) MEDICAID DSH.—In this section, the term
6 “Medicaid DSH” means adjustments in payments
7 under section 1923 of the Social Security Act for in-
8 patient hospital services furnished by dispropor-
9 tionate share hospitals.

10 (b) MEDICAID DSH REDUCTIONS.—

11 (1) IN GENERAL.—If there is a significant de-
12 crease in the national rate of uninsurance as a result
13 of this Act (as determined under section
14 1321(a)(2)(A)), then the Secretary of Health and
15 Human Services shall reduce Medicaid DSH so as to
16 reduce total Federal payments to all States for such
17 purpose by \$1,500,000,000 in fiscal year 2019,
18 \$2,500,000,000 in fiscal year 2020, and
19 \$6,000,000,000 in fiscal year 2021.

20 (2) DSH HEALTH REFORM METHODOLOGY.—
21 The Secretary shall carry out paragraph (1) through
22 use of a DSH Health Reform methodology issued by
23 the Secretary that imposes the largest percentage re-
24 ductions on the States that—

1 (A) have the lowest percentages of unin-
2 sured individuals (determined on the basis of
3 audited hospital cost reports) during the most
4 recent year for which such data are available;
5 or

6 (B) do not target their DSH payments
7 on—

8 (i) hospitals with high volumes of
9 Medicaid inpatients (as defined in section
10 1923(b)(1)(A) of the Social Security Act
11 (42 U.S.C. 1396r-4(b)(1)(A))); and

12 (ii) hospitals that have high levels of
13 uncompensated care (excluding bad debt).

14 (3) DSH ALLOTMENT PUBLICATIONS.—

15 (A) IN GENERAL.—Not later than the pub-
16 lication deadline specified in subparagraph (B),
17 the Secretary shall publish in the Federal Reg-
18 ister a notice specifying the DSH allotment to
19 each State under 1923(f) of the Social Security
20 Act for the respective fiscal year specified in
21 such subparagraph, consistent with the applica-
22 tion of the DSH Health Reform methodology
23 described in paragraph (2).

1 (B) PUBLICATION DEADLINE.—The publi-
2 cation deadline specified in this subparagraph
3 is—

4 (i) January 1, 2018, with respect to
5 DSH allotments described in subparagraph
6 (A) for fiscal year 2019;

7 (ii) January 1, 2019, with respect to
8 DSH allotments described in subparagraph
9 (A) for fiscal year 2020; and

10 (iii) January 1, 2020, with respect to
11 DSH allotments described in subparagraph
12 (A) for fiscal year 2021.

13 (c) CONFORMING AMENDMENTS.—

14 (1) Section 1923(f) of the Social Security Act
15 (42 U.S.C. 1396r–4(f)) is amended—

16 (A) by redesignating paragraph (7) as
17 paragraph (8); and

18 (B) by inserting after paragraph (6) the
19 following new paragraph:

20 “(7) SPECIAL RULE FOR FISCAL YEARS 2019,
21 2020, AND 2021.—Notwithstanding paragraph (2), if
22 the Secretary makes a reduction under section
23 1322(b)(1) of the Empowering Patients First Act of
24 2013, the total DSH allotments for all States for—

1 “(A) fiscal year 2019, shall be the total
2 DSH allotments that would otherwise be deter-
3 mined under this subsection for such fiscal year
4 decreased by \$1,500,000,000;

5 “(B) fiscal year 2020, shall be the total
6 DSH allotments that would otherwise be deter-
7 mined under this subsection for such fiscal year
8 decreased by \$2,500,000,000; and

9 “(C) fiscal year 2021, shall be the total
10 DSH allotments that would otherwise be deter-
11 mined under this subsection for such fiscal year
12 decreased by \$6,000,000,000.”.

13 (2) Section 1923(b)(4) of such Act (42 U.S.C.
14 1396r-4(b)(4)) is amended by adding before the pe-
15 riod the following: “or to affect the authority of the
16 Secretary to issue and implement the DSH Health
17 Reform methodology under section 1322(b)(2) of the
18 Empowering Patients First Act of 2013”.

19 (d) DISPROPORTIONATE SHARE HOSPITALS (DSH)
20 AND ESSENTIAL ACCESS HOSPITAL (EAH) NON-DIS-
21 CRIMINATION.—

22 (1) IN GENERAL.—Section 1923(d) of the So-
23 cial Security Act (42 U.S.C. 1396r-4) is amended
24 by adding at the end the following new paragraph:

1 “(4) No hospital may be defined or deemed as
2 a disproportionate share hospital, or as an essential
3 access hospital (for purposes of subsection
4 (f)(6)(A)(iv)), under a State plan under this title or
5 subsection (b) of this section (including any waiver
6 under section 1115) unless the hospital—

7 “(A) provides services to beneficiaries
8 under this title without discrimination on the
9 ground of race, color, national origin, creed,
10 source of payment, status as a beneficiary
11 under this title, or any other ground unrelated
12 to such beneficiary’s need for the services or the
13 availability of the needed services in the hos-
14 pital; and

15 “(B) makes arrangements for, and accepts,
16 reimbursement under this title for services pro-
17 vided to eligible beneficiaries under this title.”.

18 (2) EFFECTIVE DATE.—The amendment made
19 by subsection (a) shall be apply to expenditures
20 made on or after July 1, 2014.

1 **Subtitle C—Fraud, Waste, and**
2 **Abuse**

3 **SEC. 1321. PROVIDE ADEQUATE FUNDING TO HHS OIG AND**
4 **HCFAC.**

5 (a) HCFAC FUNDING.—Section 1817(k)(3)(A) of
6 the Social Security Act (42 U.S.C. 1395i(k)(3)(A)) is
7 amended—

8 (1) in clause (i)—

9 (A) in subclause (III), by striking at the
10 end “and”;

11 (B) in subclause (IV)—

12 (i) by inserting “and before fiscal year
13 2014” after “for each fiscal year after fis-
14 cal year 2006”; and

15 (ii) by striking the period at the end
16 and inserting “; and”; and

17 (C) by adding at the end the following new
18 subclause:

19 “(V) for each fiscal year after fis-
20 cal year 2013, \$300,000,000.”; and

21 (2) in clause (ii)—

22 (A) in subclause (VIII), by striking at the
23 end “and”;

24 (B) in subclause (IX)—

1 (i) by inserting “and before fiscal year
2 2014” after “for each fiscal year after fis-
3 cal year 2007”; and

4 (ii) by striking the period at the end
5 and inserting “; and”; and

6 (C) by adding at the end the following new
7 subclause:

8 “(X) for each fiscal year after
9 fiscal year 2013, not less than the
10 amount required under this clause for
11 fiscal year 2013, plus the amount by
12 which the amount made available
13 under clause (i)(V) for fiscal year
14 2014 exceeds the amount made avail-
15 able under clause (i)(IV) for fiscal
16 year 2013.”.

17 (b) **OIG FUNDING.**—There are authorized to be ap-
18 propriated for each of fiscal years 2014 through 2023
19 \$100,000,000 for the Office of the Inspector General of
20 the Department of Health and Human Services for fraud
21 prevention activities under the Medicare and Medicaid
22 programs.

1 **SEC. 1322. IMPROVED ENFORCEMENT OF THE MEDICARE**
2 **SECONDARY PAYOR PROVISIONS.**

3 (a) IN GENERAL.—The Secretary, in coordination
4 with the Inspector General of the Department of Health
5 and Human Services, shall provide through the Coordina-
6 tion of Benefits Contractor for the identification of in-
7 stances where the Medicare program should be, but is not,
8 acting as a secondary payer to an individual's private
9 health benefits coverage under section 1862(b) of the So-
10 cial Security Act (42 U.S.C. 1395y(b)).

11 (b) UPDATING PROCEDURES.—The Secretary shall
12 update procedures for identifying and resolving credit bal-
13 ance situations which occur under the Medicare program
14 when payment under such title and from other health ben-
15 efit plans exceed the providers' charges or the allowed
16 amount.

17 (c) REPORT ON IMPROVED ENFORCEMENT.—Not
18 later than 1 year after the date of the enactment of this
19 Act, the Secretary shall submit a report to Congress on
20 progress made in improved enforcement of the Medicare
21 secondary payor provisions, including recoupment of credit
22 balances.

23 **SEC. 1323. STRENGTHEN MEDICARE PROVIDER ENROLL-**
24 **MENT STANDARDS AND SAFEGUARDS.**

25 (a) STRENGTHENING MEDICARE PROVIDER NUM-
26 BERS.—

1 (1) SCREENING NEW PROVIDERS.—As a condi-
2 tion of a provider of services or a supplier, including
3 durable medical equipment suppliers and home
4 health agencies, applying for the first time for a pro-
5 vider number under the Medicare program under
6 title XVIII of the Social Security Act and before
7 granting billing privileges under such title, the Sec-
8 retary of Health and Human Services (referred to in
9 this section as the “Secretary”) shall screen the pro-
10 vider or supplier for a criminal background or other
11 financial or operational irregularities through
12 fingerprinting, licensure checks, site-visits, and other
13 database checks.

14 (2) APPLICATION FEES.—The Secretary shall
15 impose an application charge on such a provider or
16 supplier in order to cover the Secretary’s costs in
17 performing the screening required under paragraph
18 (1).

19 (3) PROVISIONAL APPROVAL.—During an ini-
20 tial, provisional period (specified by the Secretary)
21 in which such a provider or supplier has been issued
22 such a number, the Secretary shall provide enhanced
23 oversight of the activities of such provider or sup-
24 plier under the Medicare program, such as through
25 prepayment review and payment limitations.

1 (4) PENALTIES FOR FALSE STATEMENTS.—In
2 the case of a provider or supplier that knowingly
3 makes a false statement in an application for such
4 a number, the Secretary may exclude the provider or
5 supplier from participation under the Medicare pro-
6 gram, or may impose a civil money penalty (in the
7 amount described in section 1128A(a)(4) of the So-
8 cial Security Act), in the same manner as the Sec-
9 retary may impose such an exclusion or penalty
10 under sections 1128 and 1128A, respectively, of
11 such Act in the case of knowing presentation of a
12 false claim described in section 1128A(a)(1)(A) of
13 such Act.

14 (5) DISCLOSURE REQUIREMENTS.—With re-
15 spect to approval of such an application, the Sec-
16 retary—

17 (A) shall require applicants to disclose pre-
18 vious affiliation with enrolled entities that have
19 uncollected debt related to the Medicare or
20 Medicaid programs;

21 (B) may deny approval if the Secretary de-
22 termines that these affiliations pose undue risk
23 to the Medicare or Medicaid program, subject
24 to an appeals process for the applicant as deter-
25 mined by the Secretary; and

1 (C) may implement enhanced safeguards
2 (such as surety bonds).

3 (b) MORATORIA.—The Secretary may impose mora-
4 toria on approval of provider and supplier numbers under
5 the Medicare program for new providers of services and
6 suppliers as determined necessary to prevent or combat
7 fraud a period of delay for any one applicant cannot ex-
8 ceed 30 days unless cause is shown by the Secretary.

9 (c) FUNDING.—There are authorized to be appro-
10 priated to carry out this section such sums as may be nec-
11 essary.

12 **SEC. 1324. TRACKING BANNED PROVIDERS ACROSS STATE**
13 **LINES.**

14 (a) GREATER COORDINATION.—The Secretary of
15 Health and Human Services (in this section referred to
16 as the “Secretary”) shall provide for increased coordina-
17 tion between the Administrator of the Centers for Medi-
18 care & Medicaid Services (in this section referred to as
19 “CMS”) and its regional offices to ensure that providers
20 of services and suppliers that have operated in one State
21 and are excluded from participation in the Medicare pro-
22 gram are unable to begin operation and participation in
23 the Medicare program in another State.

24 (b) IMPROVED INFORMATION SYSTEMS.—

1 (1) IN GENERAL.—The Secretary shall improve
2 information systems to allow greater integration be-
3 tween databases under the Medicare program so
4 that—

5 (A) Medicare administrative contractors,
6 fiscal intermediaries, and carriers have imme-
7 diate access to information identifying providers
8 and suppliers excluded from participation in the
9 Medicare and Medicaid program and other Fed-
10 eral health care programs; and

11 (B) such information can be shared across
12 Federal health care programs and agencies, in-
13 cluding between the Departments of Health and
14 Human Services, the Social Security Adminis-
15 tration, the Department of Veterans Affairs,
16 the Department of Defense, the Department of
17 Justice, and the Office of Personnel Manage-
18 ment.

19 (c) MEDICARE/MEDICAID “ONE PI” DATABASE.—
20 The Secretary shall implement a database that includes
21 claims and payment data for all components of the Medi-
22 care program and the Medicaid program.

23 (d) AUTHORIZING EXPANDED DATA MATCHING.—
24 Notwithstanding any provision of the Computer Matching
25 and Privacy Protection Act of 1988 to the contrary—

1 (1) the Secretary and the Inspector General in
2 the Department of Health and Human Services may
3 perform data matching of data from the Medicare
4 program with data from the Medicaid program; and

5 (2) the Commissioner of Social Security and the
6 Secretary may perform data matching of data of the
7 Social Security Administration with data from the
8 Medicare and Medicaid programs.

9 (e) CONSOLIDATION OF DATABASES.—The Secretary
10 shall consolidate and expand into a centralized database
11 for individuals and entities that have been excluded from
12 Federal health care programs the Healthcare Integrity
13 and Protection Data Bank, the National Practitioner
14 Data Bank, the List of Excluded Individuals/Entities, and
15 a national patient abuse/neglect registry.

16 (f) COMPREHENSIVE PROVIDER DATABASE.—

17 (1) ESTABLISHMENT.—The Secretary shall es-
18 tablish a comprehensive database that includes infor-
19 mation on providers of services, suppliers, and re-
20 lated entities participating in the Medicare program,
21 the Medicaid program, or both. Such database shall
22 include, information on ownership and business rela-
23 tionships, history of adverse actions, results of site
24 visits or other monitoring by any program.

1 (2) USE.—Prior to issuing a provider or sup-
2 plier number for an entity under the Medicare pro-
3 gram, the Secretary shall obtain information on the
4 entity from such database to assure the entity quali-
5 fies for the issuance of such a number.

6 (g) COMPREHENSIVE SANCTIONS DATABASE.—The
7 Secretary shall establish a comprehensive sanctions data-
8 base on sanctions imposed on providers of services, sup-
9 pliers, and related entities. Such database shall be over-
10 seen by the Inspector General of the Department of
11 Health and Human Services and shall be linked to related
12 databases maintained by State licensure boards and by
13 Federal or State law enforcement agencies.

14 (h) ACCESS TO CLAIMS AND PAYMENT DATA-
15 BASES.—The Secretary shall ensure that the Inspector
16 General of the Department of Health and Human Services
17 and Federal law enforcement agencies have direct access
18 to all claims and payment databases of the Secretary
19 under the Medicare or Medicaid programs.

20 (i) CIVIL MONEY PENALTIES FOR SUBMISSION OF
21 ERRONEOUS INFORMATION.—In the case of a provider of
22 services, supplier, or other entity that knowingly submits
23 erroneous information that serves as a basis for payment
24 of any entity under the Medicare or Medicaid program,
25 the Secretary may impose a civil money penalty of not to

1 exceed \$50,000 for each such erroneous submission. A
2 civil money penalty under this subsection shall be imposed
3 and collected in the same manner as a civil money penalty
4 under subsection (a) of section 1128A of the Social Secu-
5 rity Act is imposed and collected under that section.

○